

Kira Schmidt Stiedenroth

Unani Medicine in the Making

Practices and Representations
in 21st Century India

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The publication of this book was funded by the DFG (German Research Foundation).

Cover illustration: Shelf with medicines in a private Unani clinic in Hyderabad (2012).

Cover design: Coördesign, Leiden

Lay-out: Crius Group, Hulshout

ISBN 978 94 6372 421 0

e-ISBN 978 90 4854 443 1

DOI 10.5117/9789463724210

NUR 740

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Acknowledgements

The present work was only possible thanks to the kind support and help of numerous persons and institutions, among whom the Unani fraternity in India deserves special mentioning. During fieldwork, I received friendly cooperation from many individuals, including: Dr. Abdullah, Hakim A. Ahmad (Delhi), Hakim A. Ahmad (Lucknow), Mr. K. Ahmad, Dr. M.R. Ahmed, Dr. Z. Ahmad, Dr. M.A. Ali, Hakim S. M.M. Ameen, Prof. R. Ansari, Dr. A.H. Ashraf, Dr. A.J. Ashraf, Mrs. A. Chakraborty, Dr. A.K. Dar, Dr. Farah, Prof. Habeebunnisa, Dr. A. Haleem, Dr. S.S. Hameed, Hakim M. Islahi, Dr. M. Iqbal, Dr. S. Iqbal, Prof. M.A. Jafri, Prof. S. Jamil, Mr. Javed, Hakim A. Kausar, Prof. S. Khalifatullah, Hakim A. Khan, Dr. A.A. Khan, Dr. L.A. Khan, Dr. S.A. Khan, Dr. S. Khatoon, Dr. A. Latif, Dr. Y. Munshi, Dr. Nasirah, Dr. A. Qadeer, Hakim A. Quddus, Dr. A. Rahman, Prof. Dr. R. Rahman, Dr. M. Raza, Dr. S. Rehman, Hakim M.A. Sajjad, Dr. Sajid, Dr. M. Saquib, Prof. M.A. Siddiqui, Dr. S.H. Siddiqui, Prof. M.H.M. Siddiqui, Dr. M. A. Shareef, and Dr. M.A. Waheed. I am particularly thankful to Dr. Amina Ather, Mr. Mohsin Dehlvi, Mr. Mehr-e Alam Khan, Dr. Syed Asad Pasha, and Prof. S. Zillurrahman, whose active assistance allowed me to meet many of the persons mentioned above. I also extend my gratitude to Neshat Quaiser for his advice and to Kiran Bhushi for hosting me in Delhi. My deepest thanks, however, go to those practitioners who allowed me to sit in their clinics and observe their daily interactions with patients.

In Germany, I am thankful for the support and guidance provided by my supervisors. Bo Sax's deep knowledge about Indian society has been a great source of inspiration since my early days as a student of anthropology, his encouragement and advice were instrumental for the present work. Stefan Reichmuth made this project possible in the first place. I am in debt for his enthusiastic interest in my research and for his invaluable suggestions. I am also grateful to my colleagues from the Unani research project in Bochum and to those at the South Asia Institute in Heidelberg. Further, I am thankful to the DFG for funding the position that allowed me to conduct research for this book.

Parts of this book were presented in conferences and colloquiums in Bochum, Edinburgh, Heidelberg, Kiel, Muenster, and Sancheong; I am grateful for the useful questions and comments provided by colleagues and students on these occasions. I am particularly thankful to Fabrizio Speziale and to an anonymous reviewer for their valuable suggestions to improve the original manuscript. I also thank Saskia Gieling from AUP for her editorial support.



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Many colleagues and friends helped me further through inspiring conversations, useful recommendations, critical remarks, access to literature, and proof reading of early drafts. Special thanks to: Md. Mujibul Anam, Didem Aydurmuş, Heri Beckmann, Cathrine Bublatzky, Elinor Chisholm, Sina Emde, Nico Henrich, Kai Fürstenberg, Susanne Kurz, Lukas Ley, Francisca Lira, Helena Lohneis, Marcel Löttsch, Karen McNamara, Swarali Paranjape, Karin Polit, Claudia Preckel, Catherine Scheer, Julia Seibert, Jacky Singh, Roman Sieler, and Till Westermann. My gratitude goes also to all my friends and to my beloved family for their constant love and reassurance. Last but not least, I owe the greatest thanks to my best friend and companion Joerg Hornung, who stood by my side with unconditional support, loving patience and encouraging words through the ups and downs of this research and writing endeavor.

Notwithstanding all the assistance received, I bear sole responsibility for any errors or omissions in this book.



Introduction

In India, Unani medicine is one of the officially recognized indigenous systems of medicine. The term Unani is the anglicized form of the Arabic *yūnānī* ('Greek'), which alludes to its origin in ancient Greece. Graeco-Islamic medicine¹ probably arrived in South Asia around the twelfth century, and it flourished during the Mughal period (Speziale 2010a). After the decay of the Mughal empire, Graeco-Islamic medicine continued to be supported in some Muslim princely states during British rule, but most of its physicians ceased to have the patronage and social status they once enjoyed. During the late Colonial Period, medicine was made a theme for the nationalist struggle for independence and the institutionalization of Unani medicine was consolidated. Currently, Unani's official support is coordinated by the AYUSH Ministry,² which is in charge of the development of so-called Indian Systems of Medicine (ISM) or indigenous medical systems of the country. Unani medicine is practiced in public and private (college) hospitals, in government research institutions, as well as by many private practitioners all over the country.

Drawing on analyses of Urdu sources, the work of historians of Graeco-Islamic medicine, and ethnographic details collected during clinical consultations, conversations, and interviews with a myriad of physicians and other actors of the Unani fraternity in India, this book unpacks what Unani medicine is today by attending to its multiplicity, scrutinizing apparent tensions between an understanding of Unani as a unified system of medicine and its multiple enactments as indigenous medicine, Islamic medicine, medical science, and alternative medicine. My research questions and ethnographic analysis have been informed by theoretical works and secondary sources related to the history and anthropology of (traditional forms of) medicine in South Asia and of Graeco-Islamic medicine in particular.

1 Throughout this work, I use the words Unani medicine, Graeco-Islamic medicine, Unani, and *ṭibb* ('medicine') interchangeably. While Unani medicine is the current official denomination in India, the term Graeco-Islamic medicine seems more apt to address this form of medicine before its institutionalization.

2 AYUSH is an acronym for Ayurveda, Yoga, Unani, Siddha and Homeopathy. It was the name of a department of the Ministry of Health and Family Welfare, Government of India, dedicated to improve education and research of these forms of medicine. AYUSH also includes naturopathy and, since 2010, *Sowa-rigpa* (Tibetan medicine). On 9 November 2014, Narendra Modi from the Bharatiya Janata Party (BJP), then newly elected Prime Minister of India, established AYUSH as a separate Ministry, naming Shripad Yesso Naik (BJP) its minister (AYUSH 2015).

Through a focus on enactments of Unani and how these emerged and were reinforced, the present work challenges an assumption commonly reproduced in studies on indigenous medicine³ in South Asia: that modern science and traditional forms of medicine are incommensurable. While acknowledging the asymmetries involved in legitimating efforts, I question the idea that the modernization of traditional medicine, with the inclusion of new technologies and medical knowledge, invariably leads to the biomedicalization and standardization of traditional forms of medicine. Further, my data presents empirical evidence on the diverse nature of medicine (Berg and Mol 1998) and proposes to rethink the apparent incommensurability⁴ between the epistemologies of Unani medicine and that of biomedicine and modern science.

Multiplicity, Practice Ontology, and Looping Effects

Answering the question ‘what is Unani medicine?’ requires examining the multiplicity of its being: an officially recognized system of medicine, medical knowledge, humoral medicine, traditional medicine, a source of professional recognition, a platform for the articulation of Muslim identity. This list is not exhaustive. It addresses some of the different enactments of Unani medicine that are dealt with in the chapters of this book. Practice ontology provides a framework for understanding how practices produce Unani medicine—not only knowledge about it.

Annemarie Mol examined how a disease, atherosclerosis, was multiple in the sense that it was enacted in different ways in the context of a Dutch hospital. Pathologists, clinicians or the patients did not see atherosclerosis differently. Rather, their practices made, or enacted, different versions of it, while still retaining its integrity as a single disease. Hence, atherosclerosis is not fragmented, but multiple: it is ‘more than one and less than many’ (Mol

3 I agree with Janes in that ‘there is no satisfactory term to refer to non-Western, indigenous medical systems’ (1999: 1803). The term ‘traditional’ medicine is problematic because it implies a lack of change (*ibid.*). Similarly, as I discuss in Chapter 1, the term ‘system of medicine’ implies homogeneity and cohesion (Attewell 2007), while practices are often characterized by a lack thereof. Throughout this book I use the terms ‘traditional forms of medicine’ and ‘traditional medicine’ interchangeably while acknowledging their limitations and flaws. The same applies for the term ‘biomedicine’ which implies more cohesion than it actually has (Sieler 2015: 159). I have refrained from using quotation marks when mentioning them.

4 Thomas S. Kuhn defined incommensurability as different standards or definitions of science (2012 [1962]: 147). He explained the incommensurability of competing paradigms as follows: ‘Practicing in different worlds, the two groups of scientists see different things when they look from the same point in the same direction’ (Kuhn 2012: 149).



2002; Mol and Law 2002: 11). When we consider objects not just as the focus of people's perspectives, but as 'things that are manipulated in practices', then 'reality multiplies' (Mol 2002: 4–5).

For Mol, only a single reality is enacted at a single time. In her study, the enactments of atherosclerosis took place in different rooms and by different persons, all within the same hospital, though. Whenever some of these enactments diverged to the point of contradicting each other, a hierarchy had to be established. This effort, which Mol calls coordination, is necessary for the preservation of unity and is characterized by the 'winning' of one enactment over the others, while incompatible ones are discarded. In this way, while there is manifoldness, there is no pluralism (2002: 84). Mol's idea of multiplicity seems to fit the object of this study, Unani medicine, very well. Like doctors and patients did in the case of atherosclerosis, hakims and researchers seemed all to agree about what Unani is, even though in practice it was enacted in different ways, as the following pages will illustrate. Following Mol, different versions of an object may create frictions which need to be coordinated, and each attempt of coordination is political, because relations of power are decisive when it comes to decide which version is enacted at each time. Authority, then, is crucial in the ethnographic analysis of ontologies of practice. However, its role should not be overestimated, as, in the case of Unani, authorities are multiple, too.

An important consequence of the shift of attention from epistemologies⁵ to ontologies in scholarly work is that instead of focusing on the preconditions necessary for acquiring true knowledge and addressing the question if representations of reality are accurate, knowledge about an object 'is not understood as matter of reference, but as one of manipulation' (Mol 2002: 5). It is here that Mol's philosophical questions meet ethnography, because the way in which these manipulations take place, i.e. the ways in which ontological politics are made, correspond to actions that can only be analysed in the making through empirical examples. Only an observation of how coordination takes place and different enactments are reconciled can answer the question of being. This is what Mol calls a 'shift from an epistemological to a praxeographic appreciation of reality' (2002: 53).

Enactments of Unani are done simultaneously in different places: a hakim who is feeling the pulse of a patient during a consultation, a practitioner

5 The usage of the term epistemology requires clarification. Hankinson has pointed out its standard philosophical meaning as 'theory of knowledge' as opposed to its use in social sciences as 'belief-system' (1995: 61). In the case of Unani both are related: the fundamental principles are determined by its theories of knowledge and vice-versa, as discussed in this book.

prescribing a medicine in a government facility, a Unani college student learning about modern research methods for her exam. At the same time, a patient may be visiting a hakim thinking of him as a practitioner of *desi* (indigenous) medicine, while the hakim himself may make claims of authority as a practitioner based on his BUMS (Bachelor in Unani Medicine and Surgery) degree, and recommend cupping as treatment because it is 'prophetic medicine'. Are all these enactments of Unani? What about patients visiting a hakim thinking that he is a vaid (practitioner of Ayurvedic medicine)? And what about BUMS graduates who officially practice Unani but, in reality, clearly use biomedical nosologies and therapies? Mol has addressed this kind of questions using her idea of distributions, through which 'difference isn't necessarily reduced to singularity if different "sites" are kept apart' (2002: 88). Mol sees distribution as spatial metaphor. While the different enactments of Unani in different settings may represent distribution as real, the idea of distribution also applies for the different contexts where Unani is enacted in different ways. Sometimes—within a single consultation, for example—Unani was represented differently without producing any friction at all. In this way, not all enactments are by definition concurrent, on the contrary: they may be even complementary to each other. The contexts set the framework through which simultaneous enactments may be considered to conflict or to complement one another.

While Mol's practice ontology approach helps us to effectively examine multiplicity without fragmentation—and hence to understand how Unani can be a coherent system of medicine while retaining a characteristic multiplicity—, it does not address the historicity of ontological practices and how they create realities on the long term. This is understandable since the context of her study, the hospital, provided a clear and manageable setting to understand the ontologies of a single disease. However, when we ought to analyse the multiplicity of something like Unani medicine in India, new questions arise: why do certain representations prevail above other ones over time? How are dominant enactments perceived as 'more real' than others, being even naturalized to the extent that they are non-negotiable in practice, while others are characterized by more flexibility? It is here that Ian Hacking's concept of looping effects (2002 [1995]) appears to be useful.

Hacking is another philosopher interested in ontology. He focused on the patients of multiple personality disorder and how they come into being as specific kinds of persons, what he called human kinds (ibid.). Human kinds are interactive kinds, they can become aware of how they are classified and they may modify their behaviours accordingly (Hacking 1999: 32). He



called this feedback effect ‘the looping effect of human kinds’ to refer to how ‘people classified in a certain way tend to conform or grow into the ways that they are described; but they also evolve in their own ways, so that classifications and descriptions have to be constantly revised’ (1995: 21). What Hacking seeks to emphasize through his focus on interaction is that things social are not just constructed unidirectionally, but they also make themselves (1999: 116). Hakims, BUMS students, researchers, government officials, manufacturers of Unani products, and even patients enact Unani in different ways, and these enactments produce the feedback effect that Hacking named ‘loopings’. Hacking’s idea of ‘dynamic nominalism’, i.e. ‘how our practices of naming interact with the things that we name’ (2002: 2) also describes very well a phenomenon explored in this book, namely the role of different denominations in the ontologies of Unani medicine. To understand how this works, a look into the history of Graeco-Islamic medicine is inevitable, even though my focus as an anthropologist rests on current social processes.

The question this book addresses is not only related to ‘what counts as knowledge in specific historical circumstances’ or ‘why particular beliefs and systems of belief arise and are accepted in particular historical circumstances, how they are sustained under relevant social conditions, and how they reflect political and economic interests’ (Lynch 2013: 451). Moreover, I seek to understand how Unani medicine, i.e. what is accepted and understood as such today—and, more generally speaking, as traditional medicine—, was made, created, constituted, and naturalized. While ‘[b]iomedicine informs anthropology on all levels of inquiry, the definition of what we aim to study, to the way in which we write fieldnotes and to the way we stake our claims in arguments with medicine’ (Ecks 2008: 85), specific enactments of traditional medicine also influenced the way in which I approached the subject of this study in the first place, namely as a problem of conflicting epistemologies between modern science and humoral-based forms of medicine. Attending to enactments of Unani medicine and the looping effects they generate makes it possible not only to acquire a deeper understanding of Unani medicine in particular and traditional medicine in general, but also to question certain tenets that have been taken for granted even in the academic study thereof.

My aim is not to prove *that* ontologies are historical and context-dependent, but to take a closer look into the processes that shape contemporary Unani medicine in India in order to understand *how* particular ontologies emerge and become established. This book examines the ways in which those involved in the realm of Unani medicine enact different ontologies



in practice (Mol 2002) while at the same time producing looping effects (Hacking 2002 [1995]) which lead to the perpetuation specific kinds or ideas, some of which this work seeks to contest.

Unani and Traditional Medicine in South Asia

Graeco-Islamic medicine has been mostly studied by historians of Muslim cultures and societies. There are only a few anthropological or sociological works dealing with Unani in the context of South Asia.⁶ If we compare the number of anthropological publications dedicated to Unani with those dedicated to other forms of Asian medicine, the marginality of Unani medicine is striking: to date, there is no single edited volume about Unani medicine, in comparison to volumes and special issues dedicated to the study of Ayurveda (Wujastyk and Smith 2008) or Tibetan medicine (Pordić 2008a; Schrempf 2007).

The dominance of Ayurveda is inescapable in the academic study of Indian medicine. Unani has been commonly mentioned in works about traditional medical systems of South Asia, but when studied more in depth it has been mostly from a comparative perspective, whereby Ayurveda received most of the attention (Bode 2008; Bright 1998; Sheehan 1983). Both Bode's and Bright's works thematized the commoditization of Unani medicine in the context of the modernization of Indian society, engaging in an analysis of how pharmaceutical products adapted to modern demands. While Bright's work was informed by phenomenological theories, as she sought to demonstrate how what she called 'everyday kitchen medicine' was related to 'the body politic of commoditized drug production' (1998: 262), Bode followed 'the social life' of Unani drugs, as proposed by Whyte, van der Geest & Hardon (2002) following Arjun Appadurai's framework to study 'the social life of things' (2013). Bode and Bright concluded that the market shaped Unani medicine, and that Unani pharmaceutical products embodied both tradition and modernity at the same time, dissolving the dichotomy (Bode 2008: 221ff.; Bright 1998: 263). Because these studies explored at length the production and circulation of Unani pharmaceutical products, I only rehearse the topic briefly in this book, even though it is of extreme importance for an understanding of contemporary Unani medicine.

6 For studies on the practice and influence of Graeco-Islamic medicine among Muslim Swahili communities in Kenya and Zanzibar see for example Beckerleg (1994), Parkin (2000; 2007) and Swartz (1997). For a study on the integration of Graeco-Islamic medicine in the Malay peninsula see Laderman (1992).

Only few other publications deal with contemporary practices of Unani medicine (Liebeskind 1996; Reichmuth 2016; Sheehan and Hussain 2002). Historians with intimate knowledge about Graeco-Islamic medicine in South Asia have criticized some of the developments brought about in the postcolonial context, notably modern research efforts aiming at the scientific validation of Unani medicine and its de-Islamization (Speziale 2010a) and the institutionalization of training (Attewell 2005; Speziale 2010a). The term ‘medical communalism’ was coined to address how Unani representatives in India often blamed the government for lack of support based on communal arguments (Quaiser 2012a). All these topics have crucially informed my research and are discussed in different chapters of this book.

The Biomedicalization of Traditional Medicines

Biomedicine has been described as ‘one of the most successful Western exports ever’, which makes it ‘ideologically, scientifically, financially and politically dominant nearly everywhere, producing asymmetries with other forms of healing’ (Naraindas et al. 2014: 6). These asymmetries have been part of recent research agendas proposing the questioning of their ‘naturalness’ and how they have been created through looping effects involving practices, institutions as well as the politics, power and resistance related to them (ibid.). Although it can be agreed that the dominance of biomedicine characterizes the asymmetries of medical pluralism in the modern world, the assumption that this was always the case is wrong (Baer et al. 1997: 212ff.). Even though traditional medical systems borrow from biomedicine in order to legitimize their professionalized branches, biomedicine’s dominance has never been absolute (ibid.). This is an important point, as it reflects one of the perceived paradoxes that guided the initial stages of this research project, based on my reading of the anthropology of Asian medicines.

In the study of what he called ‘medical revivalism in modern India’, Charles Leslie asserted that the adoption of institutions and concepts from biomedicine in Ayurveda and Unani can be seen as the continuation of a ‘tradition of syncretism’ of both forms of medicine, which had been influencing each other for a long time and whose practices were by the nineteenth and twentieth centuries already ‘radically different from the classical texts’ (1976b: 356f.). Leslie termed these ‘syncretic traditions’ that varied from the classical texts ‘traditional culture medicine’ and argued that its practitioners knew some of the classical texts but their practices were more influenced by commentaries and oral transmission (1976b: 358f.). He agreed that professionalized Unani (and Ayurvedic) physicians, i.e. those

trained in colleges and participating in institutions, practiced mostly a form of ‘popular culture medicine’ characterized by the combination of concepts such as hot and cold food, vitamins, germ theory, and religion (*ibid.*) Certainly, Leslie nailed down the common characteristics of Unani medicine as practiced in institutional settings and provided a solid basis for the study of modernization processes related to traditional medicines. While the distinction between ‘classic’ literate systems and their ‘local appearances’ was still made in the 1990s (Leslie and Young 1992: 2), the argument was moving away from the idea of corruption through inclusion of exogenous elements towards an understanding of Asian medicine as evolving and constantly transforming itself (*ibid.*).

Leslie’s depiction of the modernization process and its outcomes as ambiguities (1974, 1976b) remains a prevalent view today. His statement that ‘Āyurvedic and Yunānī medicine have evolved in an ambiguous para-professional relationship to cosmopolitan medicine [biomedicine]’ (1976b: 365) remains as relevant as 40 years ago. This is reflected in policies such as the current National Rural Health Mission (NRHM) programme by the Government of India, which seeks to fill the gaps in health care coverage through the appointment of Unani (and other non-biomedical) practitioners in rural areas where there is a lack of biomedical practitioners.

The official distinction and recognition between MBBS (Bachelor of Medicine and Bachelor of Surgery) doctors, doctors of traditional medicine, and folk practitioners who lack formal training has been discussed in papers that problematize the sanctioning of medical practices in the Indian health care system, pointing out to the hierarchies and ambiguities involved in establishing what counts as legitimate medical practices and what as quackery based on formal training which emulates the biomedical model (Bode and Hariramamurthi 2013; Lambert 2012). For the case of Tibetan medicine, it has been suggested that the different forms of training grant different forms of recognition as medical professionals, depending on the contexts where the medical expertise has to be applied (the so-called ‘taskscape’) (Pordié and Blaikie 2014). In this way, training and official recognition have adapted pragmatically, creating different kinds of practitioners of Tibetan medicine, each with a specific task to be fulfilled in a particular environment (*ibid.*).

The mingling of biomedical knowledge with indigenous medicine has been discussed as the consequence of institutionalized training. Biomedical training in colleges of indigenous medicine often serves primarily the interest of the government to fill gaps in the (biomedical) health coverage. This has impacted the practice of indigenous medicine on a larger scale in what Smith & Wujastyk called ‘the biomedicalization of Ayurveda’ (2008:



8). Harish Naraindas claimed that the inclusion of biomedical nosologies in Ayurvedic colleges lead to the creation of ‘modern doctors of traditional medicine’ (2006, 2014a, 2014b). Initially, Naraindas (2006) argued that this form of mixed training in institutionalized settings lead to a conceptual bilingualism used in medical practice, whereby practitioners shift from one language—and their belonging epistemologies—to another, given the case. He referred to the enactment of one among the competing epistemologies, i.e. Ayurvedic or biomedical, as ‘nosopolitics’ (2014a, 2014b). In a later work, however, Naraindas distanced himself from the idea of conceptual bilingualism, arguing that Creolization is a better term to describe this phenomenon because Ayurvedic practitioners are not fully conversant in both the languages of allopathic and Ayurvedic medicine, but rather they ‘speak’ a new and simplified language on its own, whereby one language—according to him that of biomedicine—dominates (2014b: 124). Like Naraindas, and in line with Leslie’s proposition of syncretic traditions (1976b), Laurent Pordié suggested that new forms of traditional medicine integrating biomedical concepts may be analysed as medical forms on their own (2008b). In his study of Tibetan medicine, Pordié proposed ‘neo-traditionalism’ as an analytical category that fairly subsumes the social phenomena at stake in producing neo-traditional practitioners (ibid.). The concept refers to forms of practices that arose in a new social, political and economic environment and which can be characterized by the appropriation of ideologies and epistemologies which, at least initially, are considered by the outside scholar to be exogenous (Pordié 2008b: 12f.).

While these works address some of the realities of the contemporary practices of traditional medicines, thus also being useful in the analysis of the Unani case, they do not correspond to all forms of contemporary Unani practice. This is because the inclusion of biomedical notions and techniques in Unani clinical practices, as some examples from the field shall illustrate, did not necessarily effect a substitution or transformation of Unani knowledge. This is precisely one of the ideas that the present work seeks to challenge, a task undertaken in Chapters 3 and 4.

The epistemological gap between traditional forms of medicine and modern science have been discussed as causing tensions. Jean Langford, for example, focused on the disparities between Ayurvedic epistemology and modern science, arguing that the ‘anxiety about how to translate *doṣa* [the equivalent to humour in Ayurveda] into scientific facts is sustained in part by the needs to accommodate the somatic imagery of modern diagnostic technologies’ (2002: 155). Her discussion of the use of modern diagnostic methods in Ayurvedic practice highlighted their failure to

visualize metaphysical elements such as the humours, creating tensions (2002: 159). These ‘tensions’ between traditional and modern ways of knowing have also been reflected in studies addressing the so-called validation of indigenous knowledge, especially regarding drugs. For the case of Ayurveda, it has been argued that a process of pharmaceuticalization is taking place, whereby Ayurvedic drugs are validated under modern scientific parameters while rendering its underlying epistemic framework superfluous (Banerjee 2004). Other authors have been critical about the use of modern scientific research—whose epistemologies are considered to be incompatible with that of traditional forms of medicine—in order to prove the efficacy⁷ of traditional medicine and its therapies (Adams 2002a, 2002b; Adams et al. 2005; Bode 2009, 2015; Bode and Payyappallimana 2013; Janes 2002; Pordié 2010), arguing against a biomedicalization of traditional forms of medicine. Here, biomedicalization means not just the inclusion of biomedical concepts and practices in indigenous medicine, but more generally the use of modern scientific research for the validation of indigenous medical knowledge as well as the pharmaceuticalization of traditional medicine. Through these, and through the use of modern diagnostic methods and other technologies considered to be biomedical, modern science is assumed to impose a biomedical epistemology on indigenous medicines, exercising thus domination in form of an ‘epistemic violence’ (Spivak 1988), whereby only the framework accepted by the international scientific community, i.e. that of Western modern science, is accepted as valid (Pordié 2014b: 50).

Two problems (at least) emerge from this critique against biomedicalization: the idea that the epistemologies of indigenous forms of medicine necessarily diverge from (or even oppose) that of modern science, and the notion that the dominance of modern science is absolute. Recent studies have proposed alternatives to the critical views which assume a divide and incompatibility between indigenous and modern scientific or biomedical ways of knowing. Notably, the ‘reformulation regime’ in the Ayurvedic pharmaceutical industry has been ‘characterised by the emergence of a world specializing in the production, the invention, and the marketing of polyherbal therapeutic specialities building on strong continuities, both conceptual and material, with India’s traditional medicines’ (Pordié and Gaudillière 2014a: 7). This regime, while strongly influenced by the modern market economy and the dominance of modern scientific research, is an

7 I use Bode & Payyappallimana’s distinction between ‘efficacy’ as the ‘outcomes of research sanctioned by the international biomedical and pharmacological community’ and ‘effectiveness’ to imply ‘the worth of treatments on the ground, i.e. for patients who make use of them’ (2013: 2).

example of how Ayurveda adapts to the current global scenario not by simply absorbing modern scientific paradigms and reproducing asymmetries by doing so, but rather by ‘reshuffling’ existent asymmetries instead (Pordié 2014a: 50). This is done through the creation of forms of an ‘alternative modernity’ (Chatterjee 1993) resting on ‘a dialectic which constantly redefines and displaces the boundaries between the “inside” and the “outside,” between what is accepted as modern and what is promoted as tradition’ (Pordié and Gaudillière 2014a: 4). While Ayurveda—through the persons involved in activities related to it—, has been recognized as being able to make use of advances related to modernization, industrialization and the global market economy for its own benefit, its relation with modern science and biomedicine continues to be understood largely as generating tensions and an ‘uneasy hybridity’ (Pordié 2015: 6) between the epistemological basis of traditional forms of medicine, the forms of new knowledge production, appropriation and circulation, as well as their commercialization (Gaudillière 2014a; Pordié and Gaudillière 2014b; Pordié and Hardon 2015) attributed to the current politics of drug discovery, production and distribution.

A close examination of concepts underlying Unani enactments invites us to reconsider the conceptualization of the relationship between Unani medicine and modern science as surrounded by ‘tensions’ based on diverging epistemologies, in accordance to the critique on binary epistemologies (Pordié and Gaudillière 2014a: 3). Perhaps one of the most important findings of the present work is that Unani medicine is not necessarily incompatible with biomedicine or modern science. Most of those involved in the practice and research of Unani medicine did not consider biomedicine or modern science to present a concurring or dominating epistemological framework against which Unani had to compete. This consideration should not be regarded merely as the product of the current dominance of modern science. Instead, it was rooted in the history of Unani medicine itself and was reflected in some of its clinical practices. While not denying the existence of tensions and an uneasy relationship between Unani medicine and biomedicine or modern science, this book proposes that these are not mainly rooted on diverging epistemologies of healing, but rather on configurations of the political and economic world order instead.

Theory vs. Practice?

For years, scholars of traditional medicines sought in classical canonical texts for the underlying epistemologies that determined physicians’ understanding of health and healing and their application in clinical



practice. Textual medical traditions were judged superior than so-called folk-healing practices, which were based mostly in vernacular knowledge. Graeco-Islamic medicine was studied by scholars of Oriental and Islamic studies with a background in history and philology (Bürgel 1976; Ullmann 1997 [1978]) before it caught the attention of a few anthropologists. The study of the texts attributed to Graeco-Islamic medicine, hence, preceded the academic engagement with their medical practices. Non-Western textual medical traditions were understood to follow their own—albeit different from the Western—rationale, and thus to be scientific in their own terms. Charles Leslie referred to humoral-based textual forms of medicine as ‘great-tradition medicine’ (1976a: 2), while vernacular forms of healing were part of what he called ‘little traditions’, following the classification of civilizations between hierarchic and lay societies laid down by Redfield (1960). As medical anthropologists increasingly studied the practice of textual medical traditions, the variations of the recorded practices vis-à-vis the texts that were considered to form their basis were explained through the influences of colonialism, modernization, the hegemony of biomedicine, and other developments such as technological and scientific advancement as well as professionalization (Leslie 1976a). Leslie was a pioneer in acknowledging these variations in medical practices not as inconsistencies, but as medical forms in their own right. He distinguished, among others, between the Ayurveda and the Unani of the texts, professionalized Ayurveda and Unani, as well as ‘popular-culture medicine’, the latter being an extension of the syncretic medicine of traditional culture, mingling concepts and practices from the textual and cultural tradition with modern concepts of vitamins, germ theory of disease, popular astrology, and religion (1976b: 358f.). Through this pragmatic approach, the different forms of practice of Ayurveda and Unani medicine were not seen as less authentic than forms of practice closer to the canonical form, but rather as different manifestations or forms of practice, each being worth of academic engagement.

Leslie’s approach continued to influence medical anthropological research of Indian medicine for decades. For instance, Langford argued that the ancient texts provide the bases or parameters that guide Ayurvedic practice. She distinguished between ‘contemporary Ayurveda’ and ‘the Ayurveda of the ancient texts’, pointing out to the broad plurality of medical practices that may be perceived as Ayurvedic by patients and healers alike (2002: 4). In spite of this separation between Ayurveda as in the texts and Ayurveda in practice, she argued that the idea of illness as the product of changes related to the three *dosas* or humours as known in Ayurveda corresponds to ‘one common thread running through these diverse practices’ (ibid.).



The humoral aspect, thus, was seen as the essential core of Ayurveda, the shared ground between classical texts and actual practice.

Ibn Sina, perhaps the most authoritative figure in the Unani tradition, understood medicine as science or knowledge (*ilm*) consisting of the knowledge of the principles underlying its practice (which he called ‘theory’ or ‘knowledge’) as well as the knowledge of the modes of practice (‘practice’). Unlike the current general understanding, practice here does not refer to the direct application of knowledge, but to knowledge about its application instead (1993: 1f.; Kurz 2014: 15f.). Following Ibn Sina, theory engages with the fundamentals of medicine and shall not be questioned by a physician, as they constitute an area of inquiry for philosophy and physics instead of medicine (1993: 4f.). The ‘practice’, by contrast, consists of knowledge based on empirical observation and reasoning and which has a practical application. While the fundamental principles underlying Graeco-Islamic medicine have remained largely constant over time, practical aspects concerning diseases and their treatments kept changing for several reasons, including the need to adapt to different environments and diseases due to geographical expansion, trade, varying religious norms, warfare and travel, to mention a few (Pormann and Savage-Smith 2007: 2).

Even though it is represented as a textual tradition, Unani medical knowledge is not only based on textual sources. As Chapter 2 evinces, innovation and originality are still considered important virtues of good hakims. Hence, analyses of concepts of health and healing should take into consideration the dialectic relationship between different entanglements of tacit and exclusive knowledge with textual knowledge and actual practice, including the representations thereof, instead of considering them as separate entities.⁸ In the case of textual-based medicine, ‘[i]t is important to recognize that both texts and practice exist in parallel and, importantly, their forms of interpretation inform one another’ (Sieler 2015: 10). The textual sources of the Graeco-Islamic tradition cannot be compared to the actual practices of Unani practitioners because they cannot be separated from each other in the first place. Unani medicine is constituted by its extensive textual tradition, be it as a ‘baseline’ or ‘common thread’ influencing practices, as Langford argued for the case of Ayurveda (2002: 4), or as an anchor for intellectual, communal, or even scientific identity, as I discuss in Chapter 1. However, Unani medicine is equally made out of practices and knowledge that is not found in the textual sources, but it is gained through intimate

8 This distinction may make sense in certain cases, however, for analytical purposes, as long as it does not suggest an actual separation between them.

lineages of transmission or own experimentation and experience. It is for this reason that the engagement with Unani textual sources in this book does not seek to compare theory and practice, but rather to understand, to any possible extent, how the multiplicity of Unani medicine is configured out of sources and practices in different contexts through looping effects.

From the Topic to Fieldwork

The present study is the product of my engagement in an interdisciplinary research project on the representations of Graeco-Islamic medicine in South Asia. In March 2012, my colleagues and I hosted a conference in Bochum to which we invited, among others, several scholars of Unani medicine from India and Pakistan, including the owner of a Unani pharmaceutical company.⁹ Their presentations ranged from topics related to the history of Graeco-Islamic medicine to pharmacological research on the efficacy of Unani therapies used for the treatment of hepatitis. They talked about the four humours, which they presented as the basis of the Unani system of medicine, and yet they explained the action of Unani remedies on terms of efficacy using modern scientific research. I was puzzled: how could they explain health and disease based humoral theory, while at the same time testing their medicines in the laboratory on rabbit tissue, drifting away from the holistic approach that Unani representatives are so proud about in order to follow standard procedures of a scientific framework that vehemently rejects the existence of the four humours? During the conference, I asked them this question, but none of them seemed to identify a contradiction in accepting both modern science and the humoral paradigm. For our guests, conducting modern research did not equate the rejection of humoralism, on the contrary: in their eyes, proving that the medicines work confirmed that the old hakims who developed Unani medicine were right all the time. I was not convinced by this reasoning. Informed by the literature, I saw their ideas with scepticism, if not with a certain degree of distress. I thought of them as influenced by the hegemony of biomedical science, which imposed its yardstick upon all forms of medicine, making them part of a power game they would never have a chance to win. I thought that modern scientific research on Unani would invariably lead to its biomedicalization, and that

9 The conference 'History, Culture and Science: Asian and European Perspectives on Complementary and Alternative Medicine (CAM)' took place from 12-18 March 2012 at the Ruhr-University Bochum.



the Unani scholars trying to demonstrate the validity of Unani medicine using modern scientific research were falling into an epistemological trap that could end eroding Unani medicine sooner or later.

About six weeks after the conference I left for India. My first meeting was with Mehr-e Alam Khan, the officer in charge of the publications at the CCRUM (Central Council for Research in Unani Medicine) in Janakpuri, New Delhi. Mr. Khan explained that proving Unani medicine scientifically was a priority for the government. After this first meeting, I left with a list of further contacts and permission to visit the Regional Research Institutes of Unani Medicine (RRIUMs) under the CCRUM umbrella in seven cities, from Srinagar to Chennai. In the following three months, I toured the country visiting practitioners, government officials, Unani colleges, and the research institutes under the CCRUM. I observed how Unani physicians made use of modern diagnostic methods and modern concepts of research with the same ease as that they explained to me the humoral theory as the basis of Unani. As an outside observer, I remained intrigued by this apparent incongruity and by how informants remained oblivious to it. I routinely asked them ‘how do you reconcile the fundamental principles of Unani medicine with modern scientific research or modern diagnostic methods?’ And every time that I asked this question, I was confronted with confused looks. ‘What do you mean?’, they would ask. Clearly, my informants were not seeing a problem where I saw one. Only later on did I realize that I was asking the wrong question.

The topic of the present work developed with research itself. Initially, I was looking at investigating the institutionalization of Unani medicine and its development as Complementary and Alternative Medicine (CAM). I soon found out that CAM was not a useful category to investigate Unani in India: Unani could be Indian medicine, Islamic medicine, prophetic medicine, humoral medicine, herbal medicine and a system of medicine; ‘complementary medicine’ was just one among the many enactments of Unani. I originally wanted to integrate non-registered hakims into my study, too, but because I entered the field with valuable official contacts—some of whom I had met at our conference in Bochum—, contacting the informal sector proved to be difficult because my initial contacts were careful to introduce me to practitioners that they considered to be best representatives of Unani medicine. Another aspect that I initially wanted to examine was the role of the textual tradition into the contemporary practices of Unani medicine. But that also became a problematic task: how could I presume to compare a textual corpus I was hardly knowledgeable about with practices that turned out to be multiple themselves?

Conducting Fieldwork

Between 2012 to 2013, I spent a total of nine months conducting multi-sited ethnographic research in India. During my first stay, I focused on institutions and on getting a general picture of Unani medicine in the country, travelling across the country to visit the CCRUM headquarters and several of its regional branch offices, Unani colleges and hospitals, out-patient departments (OPDs) in government facilities, private Unani clinics, hakims, manufacturers of Unani products and their production units, research institutions as well as government officers. I visited numerous Unani *davākhānahs* ('dispensaries') and hospitals. These visits allowed me to have long conversations with Unani physicians and, in some cases, also to observe them attending patients. The core of the clinical observations, however, took place during my second stay, when I sat in the clinics of three hakims practicing Unani medicine and one BUMS graduate who declared to practice biomedicine in Mumbai and Hyderabad. I observed their daily routines and medical consultations and sat with patients and staff in the waiting room, chatting with them. Some of the hakims and their staff invited me to share lunch and dinner with their families, thus I also had the opportunity to observe their interactions outside the professional realm of their clinics, in the intimacy of their homes and in company of their friends and family.

In Mumbai, I first spent several weeks in different clinics of the *Azim Davakhana*, a family enterprise run by Hakim Azim and his brothers. It had several branches in different locations with predominantly Muslim population in and around Mumbai. Hakim Azim had no formal training in Unani medicine, he claimed to be a *khāndānī* (family) hakim, i.e. one belonging to a family tradition. His father's life remained obscure to me, all I knew was that his father had opened the *davākhānah* ('dispensary') and that Hakim Azim had been practicing for twenty to 25 years on his own, after having learned from his father since he was thirteen or fourteen years old. Hakim Azim was between forty and fifty years old, he was a big bulky bearded man with incipient baldness, always wearing a shalwar *qamīz* ('long, loose shirt') and often a topi. He spoke in a very calmed way and would listen carefully to his patients. He was very fond of *pān* ('betel leaf'), during his shifts in the clinic he would always bring some to chew. His charming smile was reddened because of this habit.

Hakim Azim's brothers held BUMS degrees, they shared different shifts for the consultation hours in the four dispensaries they owned. I visited three dispensaries, but most of the time I observed the practices in one of them



located in a northern suburb of Mumbai known for its Muslim population and its history of multiple communal riots in the past. According to Hakim Azim, the clientele was more affluent there. The dispensary had enough space for about six plastic chairs and several benches where patients sat waiting for their turn to come inside the clinic. Sometimes, as I waited—like everyone else—for Hakim Azim to come, I observed clients approaching the counter asking for specific medicines. Most medicines consisted of an assortment of one Ayurvedic and two Unani brands, but Hakim Azim also manufactured his own medicines—albeit on a very small scale—following what according to him were exclusive family recipes.

Next to the counter, a door led to the tiny clinic. Inside, a desk was situated in front of a wall with shelves attached to it. A screen on the desk showed different images from CCTV cameras which recorded different angles of the dispensary: the cash counter, the medicine shelves, the waiting room. Many patients stared at the screen during the consultations. Hakim Azim sat on an office chair next to the desk and the door, in this way he could open and close it to let patients in and out without getting up. There was another chair close to the desk, this is where patients had to sit during the consultation. On the opposite wall there was a large bench which was sometimes used as a doctor's table. Most of the time, the persons accompanying the patients would sit on it. I sat there, too. The cream coloured walls were slightly dirty, two posters showing the anatomy of the human body with English terms were hanging on them. There was a table clock in the room, too, its tic-tac was the only audible sound in the tiny clinic during the silent moments when Hakim Azim read his patients' pulse. The patients were, in their majority, young men with sexual problems: premature ejaculation, night emissions, erectile dysfunction. Hakim Azim told me about their cases each time after the consultations. I could not follow those, as he and his patients whispered in each other's ears. My time with Hakim Azim was brief, as my presence clearly disturbed those intimate consultations with mainly male patients. He gave me the number of a Dr. Hussain and said: 'He practices allopathy, but he is the best physician I know.'

Although not a Unani clinic, the *Fakhar Clinic* run by Dr. Hussain gave me important insights into how a BUMS graduate practiced biomedicine. This small clinic was situated between Kamathipura and Nagpada, now a mostly Muslim neighbourhood known as Mumbai's red light district and infamous for its former mafias. The clinic was located in an inconspicuous small walkway with shops and private residences. Dr. Hussain knew the area since his student times, when he came as a bachelor from Uttar Pradesh (UP) and stayed with a Jewish woman as a paying guest. He obtained his

Unani degree from the former Tibbia College, where he was active as student speaker. He initially wanted to study allopathic medicine but, like many others, he decided to try Unani medicine after he was not admitted to the MBBS course. Practicing allopathic medicine was easier for him since he admittedly lacked deep knowledge about Unani. Having no family background, it would have been very difficult for him to establish himself as a reputed and popular Unani practitioner. He kept learning about biomedicine through his participation in seminars and courses, the certificates of which were displayed in the waiting room of his small clinic. He specialized in venereal diseases including HIV and AIDS.

Dr. Hussain saw his profession as a service, and because infectious diseases were common in the area, he argued that biomedicine could serve his patients better, even though he acknowledged the advantages of Unani therapies on the long term. There was a tiny dispensary attached to the waiting room of his clinic. Imtyaz, a friendly young man, handed out medicines to the patients according to Dr. Hussain's instructions. Both allopathic and Unani medicines were available from this tiny pharmacy, whereby the assortment of the former was by far more numerous. The consultation room was located next to the dispensary, it consisted of Dr. Hussain's desk and a patients table with a curtain. Next to it were shelves with sterilized syringes and antibiotics ready to use. The antibiotics were used frequently, as most of his patients came with different infection complaints. There was also a sink with sterilizing soap where Dr. Hussain washed his hands after examining each patient. The wall in front of the desk had a small opening, through it the doctor could address Imtyaz directly and dictate the prescriptions for him to hand out to the patients through another window of the small pharmacy into the waiting room. I accompanied Dr. Hussain daily during the morning shifts, from 10am to 3pm. After three weeks observing his clinical daily routine, I decided to search for a hakim actually practicing Unani medicine.

Through an Internet search I ended up meeting Hakim Ahmad at the *Ahmad Davakhana*. The Ahmad family run two dispensaries with attached clinics in two Muslim neighbourhoods in Mumbai. The Ahmad family has manufactured branded Unani products under a label funded by Hakim Ahmad's father since the late 1930s. The medicines were sold exclusively in their two clinics. Their family name was well known in Unani circles, Hakim Ahmad's uncles were also involved in the practice and manufacturing of Unani pharmaceutical products which they sold under a different label. At the time of my fieldwork, Hakim Ahmad's father was already retired and two of his sons shared the shifts in both dispensaries. Hakim Ahmad, the



second youngest son, allowed me to come to his shifts. Hakim Ahmad's five brothers were all Unani physicians, they belonged to the sixth generation of practitioners of his family. He and his brothers held Unani degrees, as did their father and grandfather. His youngest brother was passing his BUMS practical year when we met in 2013.

The oldest *Ahmad Davakhana* was located in a commercial building surrounded by other shops. From the outside a board advertised its name and the kind of medicines available there. Two men in their fifties worked at the counter, selling medicines over the counter and assisting the hakim with the files of the patients. The counter was a large wooden and glass vitrine, the walls of the dispensary were covered with brown and translucent glass bottles and plastic jars wearing the simple blue and white labels of the house's brand. A large cushioned bench was on the opposite side of the counter, where patients sat waiting for the hakim to come. Hakim Ahmad's father used to sit on it, too, just next to the door leading inside the clinic. Although he was no longer practicing due to his deteriorated health, he was still present and was greeted by patients with utmost respect. He looked fragile and vulnerable, but he was always friendly and kind to all people who came, calling the next patients into the clinic and sometimes giving them additional advice after the consultation with his son. In spite of his old age and related health problems, he would not miss any prayer, which he performed inside the clinic when his son was out in the mosque for the same purpose.

The clinic itself was a small room consisting of a desk, some chairs and a cushioned bench-cum-doctor's table. The name of his father was still on the desk he once occupied. A door led to a neglected back room where newspapers and printed pamphlets were piled beneath a layer of dust. Here, there was a computer I never saw turned on, an old wooden desk and a chair, the door leading to a toilet and a ladder leading to an upper storey where Hakim Ahmad kept some of his medical books. He would climb the ladder to bring down some books for me to read in the clinic or take home. His collection included numerous CCRUM publications in Urdu and English, as well as other books on Unani and biomedicine and copies thereof. The patients coming to see Hakim Ahmad in this clinic were mostly lower middle-class Muslims, men and women alike. A few relatively wealthy families and Hindu laborers occasionally came, too. Although he had a postgraduate degree in *Ilm al-adviyah* (Unani pharmacology), Hakim Ahmad considered himself a general practitioner.

The other dispensary was slightly different, it had been opened only recently by Hakim Ahmad. It was located close to a train station, next to a

bustling bazaar, hidden behind a front building in a dirty dead-end passage next to a shop selling construction tools. It consisted of a squared room, a quarter of its squared area was separated by walls and a slide-door. The counter was run by a man in his late 20s who asked me to call him Khan Bhai. He was a former madrasa teacher from Uttar Pradesh who had been hired for the job because of his Urdu skills, necessary in order to read the labels of the medicines as well as the prescriptions. Two cushioned benches were arranged in the dispensary, patients—mostly Muslims of low and low-middle incomes—would wait there for the hakim while reading the different Urdu and English newspapers lying around. The clinic itself consisted of a desk and a chair where Hakim Ahmad sat, in front of the desk there was a chair where I sat. On the side, there was a cushioned bench-cum-doctor's table where patients were asked to sit down. Coloured posters showing anatomical images of organs such as the heart and the liver with the name of its parts in Urdu were displayed on the walls. An analogue sphygmomanometer, a stethoscope, and a pile of books on Unani and biomedicine in Urdu and English were placed on the hakim's desk, the latter covered by a towel to avoid them getting dusty. A ventilator helped keep mosquitoes away. Unlike the other clinics I conducted fieldwork in, this dispensary was not always full of patients, perhaps because it had recently opened. On some occasions, the whole day would pass with only one or two patients coming. Because of this, he would take longer to see each case, and we spent a great amount of time talking. I learned a lot from Hakim Ahmad, he was very interested in me learning Unani medicine. After I spent nearly two months observing his consultations, I moved to Hyderabad.

I spent three months in the *Shifa Mahal* run by Hakim Sadiq, a self-made hakim who proudly claimed that all his knowledge was the product of his own self-study and experience. His motivation to learn Unani arose when his wife got seriously ill and no doctor could help her. That was, according to him, some 50 years ago. His wife passed away, but in the course of the time Hakim Sadiq had become a well-respected hakim, and even professors from the Nizamia Tibbia College in Hyderabad consulted him, as I could witness. One of his sons, Hakim Sabir, held a BUMS degree and practiced with his father. It was fascinating to see how they learned from each other: Hakim Sadiq would know a lot about Unani medicines, while his son would explain to him biomedical terminology learned in college. In this way, although Hakim Sadiq could be described primarily as a traditional hakim because of his lack of formal training and because he prescribed medicines based on his own recipes, his practice was very much open for modern medical concepts, as I discuss in Chapter 3. The

Shifa Mahal was located in the ground floor of the hakim's residence in a low middle-class Muslim neighbourhood close to the old city in Hyderabad. A framed calligraphy with a Quran verse hung above the threshold leading to the clinic, it read 'And when I am ill, it is he who cures me.'¹⁰ Each of the waiting rooms had a door leading directly to the hakim's desk. The desk faced a wall between the doors, female and male patients would seat each at the left or the right side of the desk, respectively. In this way, the hakims could see a female patient, but other men could not. Early in the morning, I was invited to occupy a small chair next to the hakim's big office chair. Dr. Farzanah was a BUMS graduate who worked in the clinic attending female patients from 9am, she had been working there since one and a half years, for a 'nominal payment'. Her main gain was to learn from Hakim Sadiq and Hakim Sabir, whom she saw as her mentors. Dr. Farzanah wanted to learn as much as she could. Her husband was an MBBS doctor running a clinic not too far from the *Shifa Mahal*, she was hoping to open her own Unani clinic for women and children one day. Another trainee was Sakinah, who claimed to have studied Unani, though according to Hakim Sadiq she was 'unqualified'. Sakinah had been coming every day to the clinic for the past four months in order to learn from the hakim's experience, too.

Behind the desk and the chairs, facing the opposite wall, there was a big table full of plastic containers with pills and powders produced by Hakim Sadiq's staff. Here, around six *davāsāz* ('compounders'), young men and women alike, handed out the medicines to the patients based on the prescription sheets, called *ciṭṭhī* ('paper'). A few patients who came only for medicines would hand their *ciṭṭhīs* directly to the compounders, bypassing the physician who was busy attending patients. Some of the young male compounders wore jeans and shirts, others shalwar *qamīz* and topi. The young women working there were always covered in black niqabs, the only flesh they showed was around their eyes and their hands and feet, just as Sakinah did. Dr. Farzanah also wore a dark abaya, but she covered her face and hair with a colourful veil, hiding all of her face except for the eyes, which shone behind rounded glasses. Hakim Sadiq normally wore a white kurta and a checked lungi and chappals, while his son wore Western wardrobe, usually dark jeans or trousers, a dark shirt, and black shoes. The clinic was both the consultation room as well as the dispensary. The corridor was also a therapeutic space: some treatments were carried out by trained members

10 'Aur jab main bīmār ho jātā hūn to vohī mujhe shifā detā hai' was the Urdu translation of the original Arabic found in the Quran (26: 80).

of the staff on patients sitting on a bench situated there or lying on a mat on the floor. Unlike in Mumbai, where the private clinics that I observed consisted of a separate room where the door could be closed in order to ensure maximum privacy, here the clinic was an open space. Sitting on an edge of the hakim's desk, a patient would have other waiting patients behind, the different physicians and the anthropologist sitting on the front, plus several compounders standing in front of the medicines table behind the physicians. In spite of this arrangement, intimacy was guaranteed when needed. Hakim Sadiq and his son would take male patients to a private chamber for a private consultation, for instance when the hakim had to examine a male patient's genitals or when he had to explain exercises to a woman who observed strict purdah. Female patients were taken by female staff to another room where the gynaecological examinations and treatments were always carried out by female staff.

Hakim Sadiq's clinic was special because it was a place of convergence and transparency. Every person could see how the physicians conducted the consultations, they could observe different stages of the preparation of medicines and how they were packed in individual doses, and also how the treatments were given. Sometimes patients were not able to walk next to the hakim's desk because their condition did not allow them to do so. In such cases, Hakim Sadiq or his colleagues and apprentices approached the patients in the waiting room. Hence, the clinic was not just reduced to the hakim's desk, but the whole *Shifa Mahal* was part of it.

My role in the field was that of a researcher and more that of an observant than a participant one. It was important to me to establish this role clearly, because I am not a medical practitioner as patients and also informants often thought I was. This was troubling at times. On one occasion, after I asked a clarifying question, a practitioner asked me sincerely, after we had spent several weeks working together: 'why are *you* conducting this research? You are no medical person; how can you understand medicine? Shouldn't a doctor better be doing this?' These questions made me feel insecure as I knew that, in a way, the practitioner was right: having a background in medicine would have facilitated my understanding in many clinical matters enormously. But that would have carried some disadvantages too, as previous medical knowledge could have biased my approach. I learned about the practice of Unani from scratch, and my lack of professional medical knowledge allowed me to approach clinical practices in a very open way. Instead of taking things for granted, I kept asking questions. This may have been irritating for some informants, but it provided invaluable insights which I hope are reflected in this study.



At some point I did become a participant, though. I was seen as part of the staff—although not as a physician—by patients and practitioners in the clinics I spent more time, and the staff also started to treat me as one of them. I was informally assigned to conduct menial jobs like collecting the prescriptions of patients, taking payments, and holding a torch while the physicians examined the nose and throat or the cervix of (female) patients. In the hectic of the clinical daily routines, it seemed natural not to just sit there taking notes. As time passed by, I assisted some practitioners with blood pressure measuring or cleaning blood after *hijāmah* ('cupping therapy') sessions with female patients. Even though I was already 'working' in the clinics, I always kept writing my notes, so that everyone could be aware of the actual purpose of my presence. I was not an apprentice, since I made clear that I did not intend to practice medicine. And yet, the two hakims with whom I spent longer time, Hakim Ahmad and Hakim Sadiq, were interested in me learning how they practiced, as they patiently explained some cases and demonstrated how their therapies worked. They told me to write down important information, and one of them even rebuked that my handwriting was too tiny, how would I understand my own notes when I came back home to study them? I explained that I typed them on my computer, religiously, every day, to which he nodded, approvingly, and said: 'Don't defame my name in Germany. You should get everything right.'

Sources and Methods

This work is based on formal and informal conversations, discussions, consultations, and observations, most of which were recorded on paper and not on tape. Writing notes during conversations seemed to me an adequate way to establish my role as a researcher, visibly recording information. This was important during the clinical consultations. My notebooks contained the core of my ethnographic fieldwork. I also taped recorded interviews, mostly during the first fieldwork period. Sometimes people who had seen me recording interviews of others asked me, while talking, 'aren't you going to record this?' I did not tape-record during the clinical consultations, as the hectic routine of the clinic made it impossible to ask each patient for informed consent. Having a recorder would have been probably intimidating to some patients, who often discussed very personal matters with the hakims. While I did not ask explicitly for consent, patients saw me taking notes. A few times, patients wanted to know who I was and what I was doing. The hakims would often answer with a certain degree of pride that I had come from Germany to conduct research on Unani medicine. Most



patients nodded approvingly, only on one occasion a patient objected to my taking notes and I dropped the pen. All the names of the patients and of the four Unani physicians have been anonymized. I have only used real names for persons who explicitly asked me to do so or when information was collected in formal exchanges, like recorded interviews. However, I have reserved the right to protect the identity even of informants who gave me their consent to mention them by name when I felt that their statements could compromise them or their colleagues.

The bulk of my ethnographic material was obtained during observations and interactions with numerous practitioners, researchers, students, producers and scholars of Unani medicine. While I initially intended to include the patients' perspective, too, it soon proved to be difficult for practical purposes. In Mumbai, where I commuted up to four hours daily to reach some of the clinics I visited, planning visits to patients at their homes in different parts of the mega-city would have cost me an enormous amount of time, which I preferred to spend observing consultations in the clinics. My interaction with patients was mostly limited to the waiting rooms of the clinics. I maintained contact with only a small number of patients after I left the field. However, most of the time I focused on the Unani professionals. Hence, the present work discusses Unani mainly from their perspective, and not from that of patients.

Apart from direct interactions in the field, I collected press cuttings of relevant news or articles related to Unani medicine, both from Urdu newspapers in the field as well as online when I was back in Germany. I also included different sources related to Unani medicine, ranging from discussions on Facebook to official regulations, from legal frameworks such as the Drugs and Cosmetics Act to advertisements found in newspapers and websites and to official booklets and publications and Unani books in Urdu and English. However, I made no attempt to be inclusive regarding these sources, as there is an enormous amount of material which, for the sake of time, I could not take into consideration even if it was available to me.