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Indigenous Therapeutics, Public Discourse and the Politics of Practice in 20th Century Colonial Bengal

Anuradha Gupta
PhD Scholar, Department of Sociology, Jadavpur University
Email: anuradhag633@gmail.com

Abstract: *State sanctioned archival documents on indigenous medicine is reflective of the practice of forgetting and foregoing in constructing an "Indian Medical System". These documents not being the only one in public discourse bears open an elite practice of institutionalisation of a dynamic field with possibilities in voices and vocation that transgresses such elite and authoritarian definitions. The public discourse is a space that not only accommodates the "official" but also a wide range of documents that have an official charge but does not fit into the restrictive scope of the statist registers of qualifying as officially sanctioned knowledge. The article attempts to make a close reading of public policy of documents of indigenous medicines in the late colonial period in India and the vast circulation of printed matters, especially Bengali periodicals publishing on the same, that were being published in those years and reading them together in a dialogue. Unlike reading them as existing dichotomously, the article attempts to study what Henry Lefebvre calls the "present" in understanding the everyday life. The task of policy makers around medical matters and practitioners in constructing an authentic charter overlooks these periodicals that supplements the former's nationalist cause as well as circumvent it. Grihachikitsa and Mustiyog, that the article will focus upon, dotting these periodicals continue to pose itself as an epistemic conundrum refusing to settle indigenous therapeutics into any dominant discourse and disciplinisation. Methodologically, everyday life of therapeutic matters will unfold the problem of knowledge formation around the historicity of these medicinal materials and also how it remains a contested field due to the policies that overlook the identities around caste, regional, linguistic and gender diversity in contributing to the epistemic repertoire of "national medicine".*

Keywords: Indigenous therapeutics, *mustiyog*, *grihachkitsa*, public policy, Indian medicine.

Introduction

The article aims at upholding a problem - a problem of location and categorisation of forms of knowledge. According to Bernard Cohn, the epistemological construct of the "Indian" has been through a classification, categorisation and containing the social world in defined boundaries. The creation of these categories has constructed a misplaced discipline of the "official", the "popular" and the "simple" form of knowledge, materials, practices and the practitioner. It has also overlooked the flawed assumption of creating a dichotomy of location in so far as putting different phenomena and objects as central and constructing a space for the relegated as "peripheral" or "at the margins". This spatial hierarchization that shifts the objects, practices and identities, identifies them as a disarrayed and amorphous body of practice that lies at margins both in terms of spatial location (the rural space, the family) as well as the problem of embedding it in any specific knowledge regime that is ratified by the dominant elite voice.

The preface to the establishment of post-colonial indigenous medical institutions and indigenous medical regulation was marked with debates about creating policies and accommodating, regulating and cataloguing therapists and therapeutics according to standardisations. It creates universal discourse of categorizing drugs and training authentic experts in the field of Ayurveda, Unani and Homoeopathic medicine. The Bengali periodicals and magazines on the other hand, kept publishing and devoting sections under the name of *oushadhtottwo*, *mustiyog*, *grihachikitsa, totka* and *bhesajtottwo* that were neither coming from the space of antiquity of Indian medical texts, a state designated *vaidya* or *hakim* nor a definitive "scientific" validity of tested medical matters. Yet, these were co-existent in the public circulation of assertion of indigenous voices in bring together a coherent and robust reservoir of indigenous medicines that had a diverse provincial history of practice and knowledge. The policies were putting forth a universal system of indigenous medical knowledge, the practical realities stemming from a range of co-terminus therapeutic works on the other hand were subverting and displacing the essentialist claims of the policy makers and elite institutions around thinking of Ayurveda, specially, as a well-rounded a priori institution that fits its antiquity well into the registers of modern medicine.

The article is divided into four sections. The first section deals with the decade long debates around institutional reorientations of indigenous medicine, heavily focussing on Ayurveda and focussing on drug regulation and procurement, in the quest to form a national collection of codified indigenous medicine. The second section will enumerate on the Bengali periodicals dealing with matters on indigenous medicine and even pages including indigenous medical practices in periodicals related to home, women, agriculture and the Bengali community's nationalist assertions. The third section gives a detailed account of *mustiyog* and *totka*, what were they indicative of, who was prescribing them and the relation of its existence to the popular proponents of *kabiraji* medicine in those years. The fourth section deals with the problem of nomenclature in settling these therapeutics and whether they can be justified as "simple" and amorphous. It also interrogates questions of medicines as subversive categories which reconstitute the idea of the indigenous and expressing themselves as possibilities that confront the essentialist therapeutic domain of the sanctioned drugs and medicines. The central argument of the paper is to show how indigenous therapeutic matters through their everyday existence has seldom been understood as an epistemic space itself but has nonetheless been a formidable force in challenging elitist nationalist narratives and forming an independent voice in public discourse.

Indigenous Medical Policies, a Nationalist Assertion and Public Memory

The Report of the Committee on Indigenous System of Medicine, was compiled in three volumes. The first official release of the first volume was in 1948, co-emergent with the Indian national state emerging as a sovereign body. It however, precedes two decades of debates and deliberations among government appointed *vaidyas* and *hakims*. The report being the first documented publication claimed a "national" voice that was not collating the provincially distributed histories of Ayurvedic practices but was trying to put forth a coherence between ancient textual precepts and modern forms of scientific knowledge. The policy's thrust was neither condescension nor reinvention and revival that we find among colonial and subsequent nationalist discourse in late 19th century. It was rather the problem of practice that was seeking to standardize medicine and regulate medical practitioners so that the epistemological lack which the policy makers were facing could be settled, amidst a constant clamour for asserting and empowering the indigenous. The members who formed the committee, the progress meetings,

arguments on drugs and rural Ayurvedic practices, showed unilateral process of institutionalising Ayurveda, but a continuous struggle in containing and disciplining the same.

The report was prepared under the chairmanship of Col. R. N. Chopra, with the members being Vaid Bishagratna, Dr. Balakrishna Chitamani Lagu, Dr. B. A. Pathak, Hakim Shifa-ul-Mulk, who were spearheading boards on indigenous medicine in Bombay, Madras, Benaras and Dhaka. Also Dr. B. N. Ghosh, a pharmacologist from Calcutta was appointed.[1] The late colonial period was now seeking a form of knowledge system for elite administrative medical practices to be established that could make indigenous medicine bereft of its diverse independent existence and reorient it as a science that could easily merge in matters and methodologies of the modern medical science. To quote from the report itself, the functions to be discharged by the appointed personnel, was 'an enquiry as to whether the three systems, Ayurveda, Unani and Modern cannot be combined into one all-comprehensive system' and responding to it, stating, 'the heritage of India, coupled with discoveries of the West, should produce a system, universal in its application and general in benefits' (Chopra 1948: 9). The policy also validates the state sanction by quoting from the Sushruta Samhita, one of the early textual compendium on Ayurvedic medicine that a practitioner after training should only begin the practice after permission from the king.

The close reading of the policy in the form of a narrative enables an understanding of those who have been purposively excluded and the practices that have been deliberately erased. The policy looks at appointing registered medical staff and supervisors in provincial and rural spaces, bringing the *vaidyas* and the hakims under the purview of medical registration and one National Board of Governance which would alleviate the positions of the Ayurvedic *vaidyas* who may be practicing under unrecognized and underdeveloped medical conditions. The policy makers also drafted a classificatory scheme of therapeutic materials by bringing them together under the category of drugs and trying to draw an anachronistic classificatory model by juxtaposing the Indological ideas on medicine and modern pharmaceutical objects. The medical and drug regulation required the *vaidyas* to collaborate with botanists and pharmacologists, in provincial and regional centres but co-ordinated under the direction of Central Research Institute and 'possibly to identify correctly most of the crude drugs and classify them' (Chopra 1948: 173). Treading along the path of the colonial botanists and administrators of creating an herbarium to archive plants and catalogue them in a fixed laboratory, under

an authoritarian gaze, like the Botanical Garden at Shibpur, the members of the national committee, Chopra and Budhwar created herbariums in the School of Tropical Medicine in Calcutta, followed by Forest Research Institute in Dehradun and Drug Research Laboratory in Kashmir. The *chikitsak* and *oushadh*, was now formally being inducted into the policy as the pharmacist and the pharmacopoeia. The autonomous body of the *kabiraj*, practicing through knowledge and training handed down through a family vocation, was also being given acknowledgement only to encourage him to get registered under a nationalized regime of Indian medicine. Ayurvedic medical matters were found to be difficult to be brought under specific categorisation and standardisation[2] of purity and potency because not only were the ancient texts on Ayurveda distributed and spread over a vast number of charters on medicine but a collation of all such matters was not easy because of the varying quantities of preparation, everyday regular use of these therapeutic matters that varied from illness to patients and the *kabiraj's* own disposition and decision.

The Report prepared by the committee was the first face of indigenous medical knowledge that was trying, even though fallaciously, to bring together a vast set of practices that involved autonomy and individual therapeutic ethics to be clubbed together as one of the scientific faces of modern Indian nation state. Such kind of nationalist assertion was based on the dubious model of first, imagining the ancient and the precolonial texts to be universalist in nature, containing a unified doctrine that could be easily made compatible with another discipline of knowledge and secondly, these being the only form of practices to which the idea of indigenous therapeutics and Ayurveda could be contained. It also is indicative of nationalisation of the space of memory and identity. Unlike thinking of the official and the everyday as two distinguished discourses, it is argued that both the spaces are implicated in one another and co-constitutive of one another. The nationalisation of public memory entails an attempt to document indigenous history in a monolithic voice that will forge a new relationship of actors, therapists, patients, consumers along a building new institutions and archives that tries to obliterate differences, co-existence and circumventions in history. However, public memory is also fraught with narratives from provincial voices, writings, oral narratives, pictures which uphold the challenges and the non-negotiability of policies and policy makers in categorising and settling a huge repertoire of therapeutic practices existing beyond state control and expressing itself with equal authority in public discourse.

Bengali Periodicals - Nationalism Revisited

In spite of not being in the same tone of the state and elite authoritarian regime in the process of documentation and archiving, a large body of printed materials were simultaneously being published through regional and vernacular bodies[3] and organisation, which were a part of an everyday life, regular readership and forging a space for a non-essentialist nationalism. These publications were either devoted specifically to indigenous medicine or a wide range of topics that contained matters of the community, but eclectically tying up all the different topical issues around identity in an anti-colonial space. The periodicals had an inclusivity of a diverse set of practices, diverse opinions and as a text, circulating in the public domain, gave a context to see co-emergent realities engaging in conversation with each other. Also, it is interesting to note, how in a diffused manner, indigenous medicine was in a dialogue with questions of gendered identity, home and family, agriculture and so on. It brought out the regular, mundane practices but not a celebration of a universalized model of nationalism. Instead, it was an expression of nationalism expressed through the intersection of a multiplicity of native therapeutics in conjunction with ideas of women and nation, children and nation and how to strengthen the space of the indigenous without silencing varied voices. To put it in another way, the epistemic conundrum which the policy makers were unable to settle in, is found to be existing as a formidable existence, punctuating public memory and revisiting the idea of nationalism.

This section will talk briefly about four such periodicals that were regularly published in the late colonial years and the initial years of the 20th century that contained precepts of indigenous therapeutics and its possibilities. *Bangalaksmi* was a periodical that was published by Hemalata Debi and started in 1924 and continued into post-independance years. Devoted to the figure of the Bengali *bhadramahila*, the periodical had issues relating to the moral and religious issues expressed through poems, stories, commentaries on women, family and motherhood. Among these articles, we find an eminent Baidya *kabiraj*, Indubhushan Sen's piece on *Shishu-khadya*, as a directive to the mother for a healthy childhood. Child health, ideal motherhood, ingestion were ideas through which nationalism gained an immense momentum, but the state authorities failed to use this register as a distributed field of looking at indigenous therapeutics. Moreover, a standardisation of pharmacopoeia often overlooks categories such as *khadya* or food as an everyday therapeutic practice that reputed *kabirajs* of that time prescribed. Moreover, food is a much broad register that has been overlooked by modern science as being prescriptive and potent in

healing, which the Ayurvedic *kabirajs* laid great stress on. The policy makers purposively forget and by-pass these forms of medical realities, because it lacks a language that can accommodate these realities. Grihastha was another periodical that was published from Grihastha Publishing House in Kolkata, a monthly periodical chronicling domestic life and rural space, through essays and poems on social and political events. Among the various topics on "Amar Bongobhumi" (my land Bengal), *Chhtrajiban* (student life), appears a column on *mustiyog*, which is a series of remedial measures, therapeutic objects and illness. The editors compile them after a month-long contribution from various sources- written and oral and there are regular contributions of indigenous medical therapies. Along with *Grihastha*, there was *Grihasthamangal*, that began publishing as a guidebook for the rural Bengal, the agrarian sector, explicitly voicing for a self-dependant agrarian and rural sector under colonial rule. The assertions of self-dependence again bring back medicine in the purview of an anti-colonial struggle to establish modes of knowing. Along with advertisements on Homoeopathic medicine and Ayurvedic medicine, mentioned as *totka chikitsa, Grihasthamangal* credits the contributors of *totka chikitsa*, enabling the readers to get a brief biographical account of the contributors, understand that medicines occupy a space of everyday vocation that neither always comes from official training nor a fixed ascriptive caste[4] status and history. It is rather dispersed and exists through remedies that are formed through sudden encounters with matters, a repeated use of them and having entered the therapeutic corpus through trials, intuitions and effectivity. A pictorial representation before every section on *Totka* medicine has a mother and child, which is argued to not only mean a certain relationship but also an intimacy to matters rising from certain domestic institutions along with family. The final periodical to be discussed is *Cikitsa-Sammilani* that was edited by Annadacharan Khastagir, a noted allopathic physician in the late 19th century and *kabiraj* Sitalchandra Chattopadhyay. The monthly journal had debates and discussions around Allopathy, Ayurveda and Homoeopathy, with popular physicians and *kabirajs* from both erstwhile undivided Bengal would contribute. It was also critical of government policies and how it should induct Ayurvedic practices in institutes. The periodical has contribution from one Dr. Mathuramohan Chakraborty of Tangail in present Bangladesh, enumerating on *mustiyog* concerning diseases of the spleen, liver.

Mustiyog, was not just amorphously spread over a non-specialized field of medicine, but also a part of the physician's prescriptions for regular use, that could be validated as a prescribed form of indigenous therapeutic material. It is also indicative of the irreconcilable medicinal practices and

practitioners that the policies on indigenous medicine were struggling to deal with and why. In spite of the nationalist claim of the home, the intimate sphere, the ethics of the native physicians and the possibilities of the body of the therapist, the official sanction does not consider it veracious enough to counter colonial forms of knowledge, since these nationalist claims themselves follow an epistemic frame that overlooks indigenous medicine to be intersected and entangled with everyday modes of identities built around gender, language and caste.

Mustiyog, Grihachikitsa and Totka – Possibilities within and Beyond the nationalist Rhetoric

The Report of the Committee on Indigenous medicine, was faced primarily with two dilemmas that it seeks to settle through a standardisation and scrutinisation. The first one was how to differentiate between an expert and a laity- designating a qualified *Vaidya* or *hakim*, and secondly, how to create an herbarium, catalogue mainly plants and putting medical matters through scrutiny of potency. The identities of the practitioner and therapeutic objects were displaced from their lived realities and socio-cultural contexts and converted into an identity that was created through a formal education structure and laboratory-controlled objects. Such identities were based on an idea of objectivity that modern science claims but in doing so tends to purposely not acknowledge the embedded realties of the daily practice of science through possibilities in time and space.

The periodicals discussed in the above section, were contributions from the Bengali community in bringing together voices supporting the cause of an emergent nation state and the need to realize the full potential of indigenous knowledge. The editors, belonged to the group of small but reputed Bengali men and women, who were publishing and voicing their views and also dedicating spaces in the columns to ideas that were at the risk of getting lost. *Mustiyog* and *totka chikitsa* or even categories like *grihachikitsa*, *khadya* needed to be kept alive through continuous publishing. It is found that the risks, non-verifiability, the gaps and the epistemic conundrum that the policy makers faced is responded through these medical existence as everyday realities among the ill, the debilitated and conveying a guide to a healthy body of a Bengali man, woman and child. These acted as a panacea for the community which was trying to express its agency and autonomy in the face of colonial episteme. It also documents histories of indigenous therapeutics from the rural and the *moffusil* areas. The editors of *Grihasthamangal*, make a plea for a

collection and documentation of *totkas* and *mustiyogs* from the *kabirajs*, physicians and the layman alike. To paraphrase from the editor's note for contributors, it says 'anyone who has any knowledge, can contribute to the propagation, will have their names credited…. Together we have to contribute in whatever amount we can and record them… individual knowledge, collected from friends and relatives will be collated and documented… it is not worthy to lament over medicines and medical knowledge being lost from memory, but to sustain it, we must act as a community to document and preserve our medicines and identities'.

Such a call, was responded from medical practitioners including the *kabirajs*, the laity and the doctors. It also talked about issues of health seldom considered important for public health but involving issues around masculinity, sex and community such as *swapnodosh* (involuntary ejaculation of semen), frailty, poisons and their remedies. *Kabiraj* Nishinath Sen, an Ayurvedic practitioner of the Baidya community, offers *totka chikitsa* for *swapnodosh* by prescribing three anna measure of roots of *shimul* tree bark or root combined with dry *amla* and butter, to be consumed every night before going to bed. Similarly, for debility, the *totka* was warm ghee with some asafoetida and rock salt to strengthen the weak body and for scorpion sting poison, to reduce the pain, tobacco leaves soaked in water was advised to be fed to the patient. The *kabiraj's* prescription was followed by some *totkas* from the supposed lower caste group men from rural Bengal. Bhupendranath Maity from Mongolmari, Midnapore, suggests that to tackle blood dysentery, honey, basil, *thankuni* leaves could act as immediate relief to people suffering from such ailment and Mrityunjoy Maity from Keshibari suggests opium as giving relief to ailments of ears and throat. Apart from the botanical knowledge, many animal products were also a part of the mustiyog. Dr. Mathuramohan Chakraborty of Tangail, Bangladesh, in Cikitsa-Sammilani writes the use of *bhasmas* of snail's shell for the treatment of ailments of spleen and liver. The editors of *Grihastha*, were welcoming contributions to the *mustiyog* collection by introducing some which have been tested and found to be effective through the editor's own encounters with the therapeutic possibilities of certain herbs, fluids and ingestible matters and also by inviting contributions through any walk of life, either to have been collected from any text or passed through aural modes of listening (*sruti*), and verbal knowledge (*moukhik*). As a footnote he credits his *jethima* (aunt), a person named Pitambar Das, who deals in herbs, a municipal *chikitsalay* at a neighbourhood in Calcutta, and a kabiraj Pyarimohan Deb, practicing in Harinavi (a neighbourhood area in erstwhile Calcutta). Kabiraj Indubhushan Sen, one of the most reputed ayurvedic

kabirajs of 20th century, wrote in details about *shishu-khadya* in *Bangalakshmi patrika*, which was a prescription not only for a child's health but also educating the mother as to how she can have remedial matters for her child's illness and how to use the kitchen in an efficient way for a healthy child and a healthy household.

The periodicals, offer an insight into the space of nationalism from the perspective of the Bengali community, upending the idea of the binary between the official, national, scientific on one hand and the domestic, expressive, intimate space on the other hand. These periodicals documented the everyday practices, vocations through aurality, familial ideas, practices in certain government sanctioned institutions, but not particularly practices tied to what the state dictates which also shows that the categories of the state, official and the domain of the layman, the domestic and the popular are implicated in each other. The policies that overlooked these intersections, were struggling to settle with knowledge and practices that were posing themselves as excesses beyond the state control. However, the public discourse, the space of nationalist assertion was punctuated with narratives from the private sphere, the autonomous institutions, medicine makers and even provincial governmental bodies. Intersections of the ideas of womanhood in late colonial years, development of recognition of indigenous medicines and native practitioners of medicine, childhood, agricultural, public health, had the presence of *mustiyog* and *totka* as domains that needed to be archived, to keep alive the quest for self-dependence, sovereign body of knowledge and practices.

Mustiyog, Totka and the Problem of the "Simple"

The meaning to *mustiyog* literally means a handful of something or the offering of handfuls. *Totka* means unverified practices as per the standards of disciplined science, seeking a truthful claim through the practitioner's belief in its effectivity and application in his immediate community. Not only have they been thought to exist in a dichotomous relationship with scientific practices and considered "unscientific", but have mostly been acknowledged as existing in the form of "simple medicines", "quackery" and "folk medicine". It is argued in this section that the social construction of these categories is based on an erroneous assumption of science being exclusively a state practice that is always regulated, whereas practices in medicine beyond it are relegated to the sphere of "irrational" and "arbitrary". The problem of such classification and dichotomy circumscribes all that have therapeutic propensities, from matters and materials that are used for

everyday therapeutics, practitioners and the question of possibilities of codifying the knowledge. As discussed in the above section, such binaries create a hierarchy and an elite form of history writing based on teleology and essentialism. The space of *mustiyogs*, *totkas* and *grihachikitsa* indicate that how the field of medicine and science is implicated in caste, gender and linguistic domain. Medicine and therapeutic matters do not exist a priori but are configured and embedded through these identities and such identities are also created through spatial history of the therapeutic matters. The universalism and the false dichotomy between what are assumed to be science and "non-science" enables a practice of bioprospecting of materials, uprooting it from the socio-cultural contexts. It creates and sustains a false binary of space also between the central and the peripheral, where the peripheral realm is carefully curated by the elites by arranging a body of knowledge assuming to be sacrosanct.

Mustiyog, on the other hand, indicates the lived reality through intersections of the multiple points of therapeutic existence, the home and gendered identity being the primary ones. The home is also the seat of nationalism, a place of sovereign assertion and hence *mustiyog* is a register of practices where such assertions mature. Writing on Homoeopathy and the domestic sphere, Shinjini Das writes that it '…demonstrated a fracturing of homoeopathy's professional identity and domain of expertise… could be written as a science that could be mastered at home and… be most useful while treating their children' (Das 2020: 169). It also was a training ground for the "ideal Hindu wife". The therapeutic matters of *mushtiyog*, entered the Bengali periodicals as training the wife of the Hindu household, to be the seat of panacea not only for the family but also the community and thereby the nation, as found in Indubhushan Sen's precepts to the householder in *Bangalakshmi*. Similarly, it was also voicing the agency of the editor's *jethima*, who constructs a therapeutic repertoire through an offering of a handful.

The marginalisation of medicine has been argued by the subaltern studies of medicine to study these ''fragments" which 'reveals the limits to statist knowledge and agenda' (Hardiman and Mukharji 2012: 15). *Mustiyog* and *Totka chikitsa* are completely opposed to the unified concept of medicine tied to a particular ascriptive space either. Studying the contributor's biography, it is spread over multiple caste identities and not just tied to the *Baidya* caste, as it claimed to be the sole seat of Ayurvedic medicine and Ayurveda also was no longer a monolithic body of medicine, but got dispersed and distributed through the topography of caste and gender. Indigenous medicine was now also within the practical application of the *Kayasthas*,

the *ojhas* and even the low caste groups of the merchants and businessman. Another reason for marginalisation within medicine is the way through which documentation has negated orality and aurality as modes of transmission of knowledge, the art of listening as forms of training and practice. It has been instrumental in creating a classical/folk binary and also a dichotomy between a master or a qualified medical practitioner and a quack. But an interrogation into the everyday life of medicines, indicate that these categories are a cultural construct of an elite historiography, statist policy intervention, which is constantly circumvented by the categories of *mustiyog* and *totka* by redefining the boundaries of therapeutic practices. In his study of the cult of *Jwarasur*, Projit Bihari Mukharji confronts the same archival error of a construction of the "folk medicine" standing in opposition to the textually instituted Ayurvedic reference to fevers. Mukharji argues that such divide would only 'naturalise the historically produced divisions between these to, not to mention naturalize the very identities of the social groups involved…. Critical history must unpack the historical contingencies of such divisions… show that classical and folk forms of knowledge have not always been distinctive bodies of knowledge belonging to distinctive social groups…. Instead, these are components of a once connected network of knowledge open to multiple socially, regionally and intellectually elaborate iterations… multiple resonant embedding' (Mukharji 2013: 285). Jean Langford argues along similar thoughts in her article on medical mimesis where she discusses the problem of creating the "quack" vis-a-vis the doctor. Unlike treating illness and therapeutics from the perspective of truth and falsehood, Langford states that it exists in simulations and simulations erode this distinction, if a simulation doctor is able to produce true wellness.

Conclusion

The Bengali periodicals, the diffused identity of the healer and the geographically, socially and culturally contingent therapeutic matters reveal the limiting and restrictive trope through which knowledge, science and identity has been constructed by the statist model of nationalism and its registers. Indigenous therapeutics that the article has spoken about also interrogates the sphere of the indigenous as a stable and settled category of thought. "Traditional" or "indigenous" as David Hardiman[5] argues the modern Ayurveda practiced in the post-colonial curriculum in India, are instance of an "invented tradition" that attempted at binding disparate people within uniform nationalism and the cultural processes not fitting into the narrative were either put into the category of the marginalized or the

excluded. This article has been an attempt in not falling in the trope of studying the "marginalised" or the peripheral, since these categories have emerged through an elitist trope of dichotomous phenomena. However, studying the public discourse of expressions of nationalism from communitarian perspective, different registers of nationalist assertions from the everyday spaces of the household, the dispensaries, the local governments and the hugely popular sphere of the prints, show that these are entangled entities which intersect the ideas of gender, medicine, caste and material realities. Also, medicines as therapeutic objects, dispersed through space, time and cultural forces show that a direct translation of medicines from an Indological study of texts and an attempt to make it compatible to biomedicine is overlooking the vast repertoire of the embeddedness of matters in socio-historical contexts and getting imbued with therapeutic values through the vocations of the agency, senses, intuitions and experiences of the therapist. The social lives of medicine in this way are a subversive reality to what Hardiman calls, creating uniform systems out of a range of eclectic practices.

Notes

1. *Report of the Committee on Indigenous Medicine*, Volume 1, 21-25
2. See, Madhulika Banerjee, 2002, *Public policy and ayurveda: Modernising a great tradition,* 1138-39
3. See, Projit Bihari Mukharji, 2009, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine*, 35-38
4. See, Projit Bihari Mukharji, 2016, *Doctoring Traditions: Ayurveda, Small Technologies and Braided Science*, 61-62
5. See, David Hardiman, 2009, *Indian Medical Indigeneity: From Nationalist Assertion to the Global Market*, 263-265

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