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Introduction to The Usman Report (1923): Translations of Regional Submissions

CHRISTÈLE BAROIS
(University of Vienna)

SUZANNE NEWCOMBE
(King's College London and The Open University (UK))

DAGMAR WUJASTYK
(University of Vienna and University of Alberta)

The historical record is dominated by the opinions and languages of those in power. For most of the modern period in India, the dominant voice is that of the colonial powers and the dominant language of the examined, extant historical record is English.¹ However, the remarkable *Report of the Committee on Indigenous Systems of Medicine, Madras* (1923), commissioned by the Madras Government in 1921, provided a unique opportunity of direct expression in their various original languages for more than one hundred of those practicing Ayurveda, Unani, and Siddha medicines in early twentieth-century India. It became known by the name of the committee's chairman Sir Muhammad Usman, KCSI (1884–1960) and hereafter will be referred to as the “Usman Report.” The Usman Report is the first major government report on indigenous medicine, and, significantly, it provided indigenous practitioners with an opportunity to put forward a strong case for more direct state encouragement and financial support.² Their testimonies came from all over India and were submitted in Sanskrit, Urdu, Tamil, Telugu, Malayalam, Kannaḍa, and Oriya, providing a snapshot of the practices and socio-

¹ Historical studies that have considered the publications of indigenous medical practitioners in the early years of the twentieth century include Kandaswamy Pillai 1979, Panikkar 1992, Hausman 1996, Alter 2004, Sivaramakrishnan 2006, Berger 2013, and Mukharji 2016.

² That is, there were earlier government reports on medicinal drugs that were based on indigenous medical knowledge, but these did not describe the theories and principles of practice of the indigenous medicines.

political positionings significant for those practicing traditional medicines in India at the beginning of the twentieth century.

Here, we are pleased to be able to provide the first English translation of the vernacular testimonies of this important document. The complete original text of the Usman Report can be found on archive.org.³

The Usman Report is presented in two parts: Part One, “The Report with Appendices,” and Part Two, “Written and Oral Evidence.” In the first volume, the “Report” section summarises the committee’s conclusions and recommendations for education, registration, and supporting the local populations in accessing affordable and effective medical care. In the opinion of the authors, accessible and affordable health care for the majority of the population of the Madras Presidency could only be possible by incorporating state support for indigenous practitioners. This section is forty-five pages divided into three chapters, Chapter I: “Introductory,” Chapter II: “Medical Registration,” and Chapter III: “Medical Relief and Medical Education,” and organised in eighty numbered sections. It concludes with about five pages in which three members of the committee clarify where their own recommendations and conclusions might differ slightly from those of the main report in a series of “Special Reports.”

The appendices to volume 1 consists of a further 157 pages:

- Appendix I: “A Memorandum on the Science and the Art of Indian Medicine” by G. Srinivasa Murti (app. I: 1-96), “a book-length study of traditional Indian medicine.”⁴ This “Memorandum” was later translated into Marathi at the request of the principal of the Ayurvedic School in Poona (Hausman 1996: 220), demonstrating that the framing of the report and its recommendations had impact in other areas of India.
- Appendix II: “The Questionnaire” sent by the committee to various individuals and associations, both within and without the Presidency of Madras (app. II: 97-98). Only a part of the answers to this questionnaire were published in the second volume of the Usman Report (“Written and Oral Evidence,” 468 pages).
- Appendix III: “The List of Correspondents”. It shows the names of persons from whom written testimonies were received, organised by language: English, Tamil, Malayalam, Kanarese, Telugu, Oriya, Sanskrit, and Urdu (app. III: 98-101).
- Appendix IV: “The Constitution of Sub-Committees” according to language: Tamil, Telugu, Malayalam, Urdu, Sanskrit, Kanarese (i.e., Kannaḍa), Oriya, and English (app. IV: 101-102).

³ Both volumes can be found at <https://archive.org/details/UsmanReport>.

⁴ Wujastyk 2008: 50.

- Appendix V: “The List of Witnesses” who were examined orally (app. V: 102-103).
- Appendix VI: “The Programme of the Touring Sub-Committee” in Bengal, United Provinces, Delhi, Punjab, Ajmere-Merwara, Jaipur State, Bihar, Bombay, Hyderabad State, Mysore State, Cochin State, and Travancore State (app. VI: 103-106).
- Appendix VII: “The Statistics of certain existing institutions of Indian Medicine” (app. VII: 106-116).
- Appendix VIII: “Certain Schemes of Study of Indian Medicine” summarises the syllabus of sixteen authoritative teaching institutions of Ayurveda, Unani, or Siddha medicine from all over India: Madras, Jaipur, Bombay, Calcutta, Lahore, Haridwar, Mysore, Trivandrum, Kangri, and Delhi (app. VIII: 117-134). Most of these elements were collected by the touring sub-committee.
- Appendix IX: a valuable and extended “List of Indian Medical Works Extant (Both Printed and Manuscript)” (app. IX: 135-153).
- Appendix X: “G.O. No. 1351, P.H., dated 17th October 1921” (app. X: 153-157). This is a copy of the executive order establishing the committee, the particular individuals appointed, and terms upon which they may claim travel expenses.

The Usman Report was very much a part of the growing “domestic production” (*swadeshi*) and self-rule (*swaraj*) movements. Although colonial powers had long supported medical care and training based on a European model (Arnold 1993: 55-56), the majority of the population only had access to treatment administered by those trained in more traditional ways, in vernacular languages, outside of the colonial systems. Despite a lack of colonial support for indigenous practitioners, it is clear that traditional medical training continued to be provided in vernacular languages throughout the Indian subcontinent. Some princely states and local governments did provide financial support for indigenous medical practitioners and traditional medical training systems; these states included Hyderabad, Mysore, Baroda, Indore, Jaipur, Travancore, Cochin, Gondal, Rewa, and Gwalior (Wujastyk 2008:49).

There was growing popularity for the argument that Indian bodies should be self-reliant in order to throw off the yoke of colonialism. This argument, based on one of the fundamental principles of Indian classical medicine according to which environment, food, and customs are important criteria for diagnosis and remedy, is often invoked in the Usman Report. For example, A. Z. Muhammad Lati-funddid Sahid, who administered both Unani and Siddha medicines, stated:

Patriotism and experience make me believe in the indigenous systems [...]. We cannot trust allopathic medicines on persons constitutionally unfitted to receive them. For the constitution, the climatic conditions, the habits, and food of the people of this country, the indigenous systems are best suited.⁵

Various anecdotal reports suggest that the general population of Madras was sceptical of the accessibility and efficacy of the new, European forms of medicine (Hausman 1996: 97 and Gayathry 2012: 169-170).

In the area of the Principality of Madras, attempts had been made by local Ayurvedic practitioners (*vaidya*) and educated Indians to bring up the standard of education for indigenous medical practitioners since at least 1902 with the founding of Arya Vaidya Sala at Kotakkal. There were other initiatives in other areas of the country like the Madrasa Tibbia that functioned under the Anjuman-e-Tibbia society in Delhi, which was established as a training institution for Unani medicine in the 1880s, but was significantly raised in influence in the early years of the twentieth century (Berger 2013: 62-66). Projit Mukharji documents early attempts at the organisation of Ayurvedic practitioners in Calcutta from 1871, but gaining more stability in the early twentieth century (Mukharji 2016: 40-44). On the national level, the All-Indian Ayurveda Mahasammelan (Congress) was organised in 1907 as a professional interest group for Ayurvedic *vaidyas*, lobbying for greater recognition and professionalisation of Ayurveda.

Within the large area of the Madras Presidency, educated and politically active Indians had been arguing in vernacular papers since at least 1914 that indigenous medicine was both cost-effective (most remedies were more affordable than those recommended by European-trained doctors) and, crucially, also most accessible to the majority of the Indian population (Hausman 1996: 120 fn. 77, 143, and 171). Meanwhile Gandhi was directly criticising European medicine as being a tool of colonial oppression. A Telugu translation of Gandhi's words appeared in the Telugu newspaper *Andhrapatrika* in May 1920:

The profession of medicine is one of the chief means used by the English to keep us as servants ... The hospitals are institutions helping on sin; they lead to men neglecting the rules of health and continuing to indulge in immoral life. The state of the European doctors is very unjust. In the name of the

⁵ Usman Report, vol. 2, "Oral Examination of Witnesses," p. 452. During the 1920s, although only alluded to once in the Usman Report, there was a parallel revival of Indian forms physical culture as a way to reinvigorate and strengthen Indian bodies and prepare them for self-rule (Alter 2000 and Singleton 2010).

protection of human bodies, they yearly kill some thousands of animals (Gandhi in Hausman 1996: 215).

The Congress Party began passing resolutions in support of government patronage of Ayurveda in 1920, and the commissioning of the Usman Report by the Madras Government in 1921 was part of the growing interest in reviving indigenous medicine as respectable and acknowledging the continual role it played in the healthcare of the majority of the Indian population.

From 1912-1917, the Government of the Corporation of Madras (responsible for the municipality with some autonomy from the Government of Madras Presidency) financially supported some Ayurvedic dispensaries within its area of jurisdiction. This expenditure was not made without complaints from the Presidency Government, who in government records denounces any sign of official support for “quack remedies,” deeming it below the dignity of a medical professional to even inspect such institutions (Gayathry 2012: 172-173). Beginning in 1914, A. S. Krishna Rao was pressing the Presidency Government to invest in investigating and funding improvement in indigenous medical provision as the only accessible healthcare available to the majority of the population. However, it is clear from records of discussions within the government that those with European biomedical qualifications considered any association with indigenous medical practitioners to be a tarnish on their reputation and the standards of medical care which they might provide. For example, in 1918, the Surgeon-General of Madras G.G. Gifford was recorded as arguing:

So long as a man belongs to a Profession, the Profession must be in a position to enforce certain definite rules of conduct.... Am I to be expected, by Law, to meet the absolutely uneducated and completely degenerated quacks of the bazaar who choose to call themselves Ayurvedic or Unani practitioners. Whatever law you pass you will not affect the conduct of a medical man, at any rate, a properly behaved decent medical man (Gifford in Hausman 1996: 266)

Eventually, with a sense that their arm was twisted by popular sentiment, in 1917 the Presidency Government agreed to fund an investigation into efficacy of indigenous drugs, questioning the existence of any indigenous medical tradition that could be considered a “system” worthy of investigation. Actually, this particular commission was only the latest in a series of colonial reports and investigations into “indigenous drugs” which sought to explore the possibilities of producing

cheap and effective medicines on Indian soil (e.g. Dey and Mair 1896 and see Berger 2013: 55-60).

Although the sponsors of this report hoped to further support indigenous medicine in the area, the immediate result appeared to be quite the opposite and more in line with the well-recorded prejudice of the members of the Madras Presidency trained in European medicine against any association with indigenous medicine, which was generally considered a form of unsystematic and archaic quackery. After several years of delay, a report on indigenous drugs authored by Dr. M. C. Koman on behalf of the Madras Presidency appeared in 1920.⁶ Koman appears to be a Western-trained physician with no background in Ayurveda. Although he undertook to read a few books of background material, including an English translation of *Suśrutasaṃhitā* and a Malayalam translation of the *Carakasāṃhitā*, the conclusion of Koman's report was that "there is very little if anything to be learnt from the methods of treatment followed by practitioners of the indigenous systems" (Gayathry 2012: 185-189).

Popular response to Koman's report was a sense of betrayal and outrage. The vernacular papers, often associated with social reform and *swadeshi* movements, were quick to criticise Koman's lack of understanding of indigenous methods of treatment. The Telugu-language *Andhra Patrika*, the Tamil-language *Swadesamitran* and *Vaidya Kalanidhi* as well as the Malayalam *Yogakshemam* all published criticisms of Koman's assessment of indigenous medicine (Hausman 1996: 188-190 and Gayathry 2012: 189-191). Meanwhile pointed and angry criticism against the Presidency Government's prejudice against indigenous medicine was published in English in *The Hindu*, thus likely to have been read by those in power.⁷ Two Madras-based professional organisations for Ayurvedic practitioners, the Dravidya Vaidya Mandal and Madras Ayurveda Sabha, undertook to study Koman's report in depth and produce a professional response (Dravidya Vaidya Mandal 1921).⁸ At a joint meeting held on 21 March 1921, the Dravidya Vaidya Mandal and Madras Ayurveda Sabha issued a joint statement affirming that Koman's report was so:

incorrect, incoherent, misguided and prejudiced that he has thoroughly proved himself to be unequal to the task he has undertaken of comprehending the

⁶ For a summary of Koman's report, see Hausman 1996: 172-179 and Gayathry 2012: 185-189.

⁷ A series of excerpts of this discussion in *The Hindu* is reproduced in Dravidya Vaidya Mandal 1921, app. III and IV, iv-viii.

⁸ The complaints and lobbying by the Dravidya Vaidya Mandal for a response to the Koman Report was initially funded by a group of Madras-based lawyers (Dravidya Vaidya Mandal 1921: iii).

indigenous systems of medicine, both in their theoretical and practical aspects, that therefore the said report is not worth the money spent on behalf of it, and finally that the Government have grievously erred in appointing one single man without any previous knowledge of indigenous systems of medicine for the task of investigation unassisted by any competent Vaidya or Hakim (Dravidya Vaidya Mandal 1921, app. II, i-ii).

It seems likely that the pressure these groups put on the Madras Government led to the resources being given to Muhammad Usman to conduct a more wide-ranging consultation on the practice of indigenous medicine. Although the original resolution to the Madras Presidency suggested the establishment of a committee to investigate and encourage indigenous medicine, it was passed upon the removal of the idea of 'encouragement' and that the committee entirely consist of non-officials. In the words of the Acting Secretary to the Government of Madras, F. J. Richards:

so far as I am aware, the advocates of the Ayurvedic and Unani systems have never yet stated their case in writing for scientific criticism, and the natural impression among scientific men is that the advocates to these systems know very little about them (Richards in Hausman 1996: 204).

Therefore, the Usman Committee was established in order to build-up an evidence base and provide an intelligent rebuke to the government's assumption that the European medical approach was the only scientific and efficacious system for promoting health.

In the summary of its more comprehensive consultation, the Usman Report did not mince words in voicing its concerns about what it saw as the European medical practitioner's wilful misunderstanding of indigenous methods of healthcare. The Usman Report was especially scathing at the tendency of European-trained doctors to attempt to exploit single ingredients for curative effect, without understanding the traditional systems and compounds in which particular plants might be used by a traditional medical practitioner:

[...] the use of remedies of the Indian systems by practitioners of Western medicine may really amount to, as we said before, unscientific and dangerous quackery; [...] it is necessary for the scientific and safe use of drugs and other remedial measures used by the practitioners of the Indian systems that the fundamental principles at least, such as the *tridoṣa* theory, the theory of *rasa-vīrya-vipāka-prabhāva*, and so on, on which the use of these drugs is based,

should be properly understood. We are therefore clearly of the opinion that to practice the art of medicine without a study of the science on which the art is based is undoubtedly quackery, whether it is undertaken by the followers of Indian or European medicine who would dabble in the use of therapeutical measures of the European and Indian medical art respectively without a knowledge of the science on which such use is based; quackery, whether practiced by the followers of the Indian or European system, is always undesirable, frequently dangerous, and sometimes even disastrous (Usman Report, vol. 1: 11-12).

This was a report with a clear agenda: to undertake an evidence-based survey of the principles of indigenous medicine by respected practitioners of those arts. The way the report was framed excluded equally as quacks much of village healing traditions as well as biomedical practitioners dabbling in indigenous herbal remedies.⁹

One of the recommendations of the report was that indigenous practitioners keep more systematic records of the efficacy of their treatments in curing specific complaints.¹⁰ The issue was to demonstrate the scientific value of Ayurveda, Unani, and Siddha medicine by providing evidence of its efficiency being at least equal to that of biomedicine, if not often superior. Anecdotal reports suggested that indigenous medical experts were also likely to be approached for ailments that were more chronic in nature. For example, Dr. Kaviraj Gananatha Sen claimed that

Western-trained medical men very often request the services of their Ayurvedic colleagues in chronic intractable cases, not only among their patients but also among their own family members. This is the everyday experience with me and several of my colleagues in Ayurvedic practice (Usman Report, vol. 1: 7).

The claim for the superiority of indigenous medicine is expressed in particular with regard to the range and variety of the medicinal substances used. For example, G. Srinivasa Murti in his “Memorandum on the Science and the Art of Indian Medicine,” notes that

⁹ This is a theme also discussed by Kavita Sivaramakrishnan in her study of indigenous medicine in colonial Punjab (2006: 234-235).

¹⁰ An issue that was a subject of criticism previously by the Madras Presidency Government (Gayathry 2012: 172-173).

there are hundreds of drugs, vegetable, animal, and mineral, used widely by Ayurvedic practitioners which their know-all Western-trained rivals have not even heard of yet. Some of these are: black and red sulphides of mercury (*kajjali*, *rasaparpaṭī*, *rasasindūra*, *makaradhvaja*, etc.), various forms of iron oxides (*lauhabhasma*) which, by the way, are far more assimilable and much less constipating than Western preparations of iron, tin oxides and chlorides (*vangabhasma*), zinc carbonates (*kharparabhasma*), *śilājatu*, a valuable bituminous drug highly effective in urinary diseases, etc. (Usman Report, vol. 1, app. I: 67).

More generally, there is the recurrent idea that indigenous systems address causes of disease while biomedicine treats (only) the symptoms of diseases.

In order to put indigenous medicine on an equal institutional footing with biomedicine, one of the major recommendations of the Usman Report was to create standard registration and training systems for indigenous practitioners to ensure that adequate standards were maintained to prevent quackery by those without proper grounding in the fundamental theories of the medical systems (Ayurveda, Unani, and Siddha). The need for some standardisation in registration was highlighted in the Usman Report by discrepancies in figures for medical practitioners in the census (self-reported) and by local authorities (who held their own standards). The Usman Report estimated that the Madras presidency held a population of about 42.3 million people which was provided for by around 4,000 European-trained medical professionals and no less than 21,000 (self-described) indigenous practitioners (vol. 1: 16). In order to promote the general health of the Indian population, the Usman Report concluded that there was an essential need for more state support and oversight of those medical practitioners, trained in indigenous methods, who were, in fact, administering the majority of medical treatment in the country.

The second volume of the Usman Report is entirely devoted to “Written and Oral Evidence.” In response to a questionnaire sent all over India, the committee received 183 written submissions. The majority of the written testimonies received were not submitted in English, but in Tamil: 76 written testimonies in Tamil, 49 in English, 24 in Malayalam, 11 in Sanskrit, 10 in Kanarese (i.e., Kannada), nine in Urdu, three in Telugu, and one in Oriya (Usman Report, vol. 1, app. III: 98-101). However, Part II only contains a selection of the written submissions that do not reflect this proportion in terms of vernacular languages. The majority of the published written evidence is in English, which was also the language of the formal summary of the committee and, of course, the Government of the Madras Presidency. In appendix II, the distribution in terms of languages

and medical systems described is as follows. “From Outside the Presidency of Madras” (Usman Report, vol. 2: 1-214) includes:

- Twenty-six testimonies in English, of which twenty-four relate to Ayurveda and two to Unani medicine;
- Five testimonies in Sanskrit which all concern Ayurveda;
- Five testimonies in Urdu, three of which relate to Ayurveda and two to Unani medicine.

Written submissions “From the Presidency of Madras” (Usman Report, vol. 2: 215-428) includes:

- Sixteen testimonies in English, seven of which relate to Ayurveda, six to Siddha medicine, two to Unani medicine, and one to “mantric” medicine specializing in snake bites;
- Five testimonies in Sanskrit which all concern Ayurveda;
- Ten testimonies in Tamil, nine of which relate to Siddha medicine and one to Ayurveda;
- One testimony in Telugu on Ayurveda;
- One testimony in Malayalam on Ayurveda;
- One testimony in Kannaḍa on Ayurveda;
- One testimony in Oriya on Ayurveda.

The Usman Report also gives a significant place to the testimonies of practitioners who were examined orally (Usman Report, vol. 2, “Oral Evidence”: 429-468). The oral examination of over forty indigenous medical practitioners was held from 25 to 30 September 1922 at the committee room of the Council Chamber, Fort St. George, in Madras. According to the recommendations that precede the “Questionnaire” (Usman Report vol.1, app II: 97-98), the witnesses for the oral examination were chosen amongst those who had sent written reports.¹¹ The committee organised over forty oral examinations, however the “Oral Evidence” includes less than forty transcriptions because some practitioners came in small groups of two to five people representing a single institution.

The “Questionnaire” addresses indigenous medical practices in their theoretical, practical, economic, and institutional aspects. While many of these questions betray leading assumptions and agendas of those commissioning the report, they are also very revealing of a genuine intellectual search for answers, both on the individual and collective level. The first two questions are particularly important and give rise to often very detailed answers. There is a very apparent comparison with European medicine implicit in the questions which included:

¹¹ Therefore, some individuals provided both written and oral submissions.

- 1) What is the division, or divisions, of the indigenous systems of medicine – Ayurveda, Unani or Siddha – that you propose to deal with?
- 2) (a) What are the theory, or theories, of causation of disease according to your system? Please favour the committee with your views as to how far your theory or theories stand the tests of modern scientific criticism.
(b) What are the principles and methods of diagnosis and treatment followed in your system? Please favour the committee with your views as to the general efficacy of treatment adopted in your system, supporting your statements with facts and figures wherever possible.
(...)
- 5) Do you agree with the view of the Calcutta University Commission that “There is an obvious and promising desire at the present moment among the numerous adherents of these (indigenous) systems for closer touch with modern scientific methods. In time, no doubt, they will be able to make available for the practitioners of Western medicine the traditional knowledge which is of real value and will reject, as Western medicine continually rejects, those theories which are mere survivals, and cannot stand the test of experiments. The distinction between Indian and Western ‘systems’ of medicine will then disappear.”
If you agree that a unified system of medicine as indicated in the above passage is the ideal to be aimed at, what steps would you suggest for the fulfilment of such an ideal?
(...)
- 9) What, in your opinion, are the causes of decay of the indigenous systems of medicine? Kindly favour the committee with your suggestions of revival.

The first question concerns the positioning of the practitioner among the different Indian medical systems: Ayurveda, Unani, and Siddha. The respondents usually had a definite, articulate, and evidence-based opinion on the definition, origin, and value of their respective systems. The second question often elicited extended discussion on theories of disease causation and extensive reflection on practices and the extent to which European and indigenous traditions may or may not be compatible or complementary. There was no simple or standard answer to these questions.

Many doctors showed a knowledge and awareness of multiple indigenous medical systems as well as most of the witnesses whose words are transcribed in the part “Oral Evidence.” Likewise, all the respondents affirmed that they did not use English medicine; this is unanimous, regardless of the indigenous system to

which the doctor primarily affiliated. Nevertheless, as both questions 2) and 5) show, they were subjected to the injunction to demonstrate the scientific character of Ayurveda, that is to say, to make it correspond to the same questions, definitions, methodology, and efficiency established by the Western scientific tradition. This is particularly evident in the recommendations that precede the Questionnaire:

As under the terms of their reference, the committee is required to subject the evidence gathered to scientific criticism, witnesses are requested to support their arguments [...] by proofs or testimony acceptable to modern science, such, for example, as the evidence of directly demonstrable or observable facts, or of facts indirectly inferable, by logical methods of the nature of induction and deduction, known to modern science, or by showing that a proposition has the hypothetical certainty of a coherent system of assumptions or the practical or pragmatic certainty of a hypothesis that works best. Witnesses are also requested to note that the authority of revelations or venerated texts or uncriticisable tradition, however high its evidential value may be in other matters, are not accepted by modern science as valid testimony unless it is also capable of being proved by one or other of the methods already indicated (Usman Report, vol. 1: 97).

Therefore, the practitioners often addressed European medicine (called “allopathy” by them) by trying to find equivalent concepts to germs, cells, and hormones in their own indigenous system. A primary challenge being addressed in this work seems to be the conceptual discord between germ-theories of disease and descriptions of imbalance as the framework for understanding illness. For example, M. R. Ry. Ayurveda Bhushana Pandit C.V. Subramania Sastri sought to give Western scientific equivalents to the three humours: *vāta* “is of the nature of nervous impulses,” *pitta* is the “oxidational process,” and *śleṣma* is the “lymph” (vol. 2: 227). The whole Usman Report is thus imbued with this compelled aspiration to comparativism.

Question nine introduces the idea that indigenous medical systems had come into disrepute and “decay.” Many of the responses confirm this notion, citing lack of government encouragement and especially funding as the main reason for it. Some of the Ayurvedic respondents suggested that a greater reliance on ancient texts and theory for the practice of medicine would allow it to be taken more seriously as a scientific endeavour. The ancient Ayurvedic treatises are thus widely quoted, the *Carakasamhitā*, the *Suśrutasamhitā*, and the *Aṣṭāṅgahṛdayasamhitā* in particular with regard to Ayurveda. A very elaborate syllabus is often

described, one that takes into account the progression by years and disciplines studied, reference works, and languages required. A major point in most responses is the language of learning: Sanskrit is necessary for Ayurveda, Tamil for Siddha medicine, and Urdu and Persian for Unani medicine. Knowledge of these languages usually appears as a prerequisite for learning the respective systems in the opinion of many of those submitting evidence.

An interesting and important contribution of the Usman Report is the placement of Siddha medicine on an equal footing with Ayurveda and Unani. In fact, this may be the first mention of Siddha as a specific form of indigenous medicine in a government report. The inclusion of Siddha had not been planned for in the framing of the commissioning of the report, which only mentions Ayurveda and Unani. However, popular opinion and the testimony of the witnesses required a reframing of the enquiry to include Siddha alongside Ayurveda and Unani (Usman Report, vol. 2: 153 and Hausman 1996: 206-207). A total of fifteen written submissions are from those who identify primarily as Siddha practitioners, including six (of sixteen) reports submitted in English and nine of ten contributions in Tamil (these submissions are translated into English in the present volume). In the first volume, the Usman Report specifically draws attention to the contributions of Narayanaswami Ayyar, “who has made a special study of chemistry as obtaining in the Siddha schools of medicine,” and Vaidya Bhupathi S. Krishna Rao, who gave a detailed oral testimony of Siddha medicine (Usman Report, vol. 1: 46). The “Memorandum on the Science and the Art of Indian Medicine,” which presents a short, book-length summary of traditional Indian medicine, devotes a few pages to the Siddha system, in its ninth chapter entitled “Additional Note on the [Tamil] Siddha System” (Usman Report, vol. 1, app. I: 82-87).¹²

The first question of the “Questionnaire,” which asks which “division, or divisions, of the indigenous systems of medicine – Ayurveda, Unani or Siddha” the practitioner is working within, provides an unexpected opportunity for Siddha practitioners to define their system and to place Tamil Siddha medicine in relation to the other South Indian medicines, showing a specificity and enthusiasm for a Tamil claim to a particular medical tradition. The responding Siddha doctors used discursive strategies to place Siddha medicine at the same level as Ayurveda while retaining its uniqueness. Richard Weiss has analysed the Tamil sources’ response to this question, noting an ambiguity and overlap as to whether or not Siddha was a distinct system of medicine. Weiss concludes that “In calling their practices ‘*Tamil Ayurveda*’ or ‘*Tamil medicine*,’ they emphasised that they followed a medical tradition that drew upon Tamil texts rather than Sanskrit texts. Yet in calling their practices ‘*Tamil Ayurveda*’ they also assumed an overlap between

¹² There is also “An Additional Note on the Unani System” in app. I: 87-95.

the medical practices and theories continued in these Tamil texts and those of Sanskrit sources” (Weiss 2009: 86).

Indeed, the majority opinion in the Usman Report is that both the Siddha and the Ayurvedic systems have the same common foundations (Usman Report, vol. 1, app. I: 3 and 82). This was accepted by most Siddha practitioners, although they also emphasised the unique features of the Siddha tradition, particularly in regard to its reliance on the use of inorganic substances, i.e., salts, metals, and minerals, and also in regard to its use of distinct textual authorities such as the *Tirukkural* or the *Tirumantiram* of Tirumūlar.¹³ Neither the *Tirukkural* nor the *Tirumantiram* of Tirumūlar are exclusively medical texts: the *Tirukkural* (The Sacred Kural) is a “comprehensive manual of ethics, polity and love in 1330 distichs divided into 133 sections of 10 distichs each” and contains a section dedicated to medicine.¹⁴ The *Tirumantiram* (The Sacred Mantra) is “included in the 10th book of the Śaiva canon.” It is a mystico-religious work that combines yoga, medicine, alchemy, etc. in a poetic language. More generally, texts of the Siddha doctors are often enriched with poems, sometimes with esoteric or encrypted meanings (see Kędzia 2017 and Weiss 2009).

Richard Weiss contrasts this positioning in the Usman Report, which stresses commonalities and overlaps between Siddha medicine and Ayurveda, to the position of many Tamil medical practitioners in the early twenty-first century which draws more directly from a Tamil separatist narrative that gives Tamil medical traditions a distinct and separate origin to Ayurveda on the primordial continent of Lemuria (Weiss 2009: 87).

Only few of the respondents claimed superiority for the Tamil Siddha tradition. For example, Siddha practitioner M. R. Ry. Pandit Shanmuganandaswami asserted that

Tamil siddha medicine is superior to all other systems of medicine in the world. The reason for the superiority of Tamil medicine is that it has a gem (*maṇi*) and a medicine to promote longevity (*kaṛṇam*) that protects a person from greying hair (*narai*), wrinkles (*tirai*), old age (*mūppu*), and even from death (*cākkāṭu*). Other systems merely cure diseases and provide a good life based on soft (*tēva*), moderate (*maṇita*), and hard medicines (*acura*). One can learn this method only from yogis and not from other people. We also cure

¹³ The date of the *Tirumantiram* remains uncertain. Goodall notes that “The placing of Tirumūlar’s *Tirumantiram* between the fifth and the seventh century is widely accepted on the basis of scant evidence.” On the grounds of concepts with Sanskrit labels in the text, it would not be earlier than the eleventh-twelfth centuries (Goodall 2000: 213, fn. 27 and also see Scharfe 1999).

¹⁴ *Tirukkural* 941-950, “On medicine” see Zvelebil 1995: 669-671.

diseases using a gem (*mañi*), mantras, and medicine as available, in the Tamil system of medicine (Usman Report, vol. 2: 340).

However, this sentiment seems to not have been shared by the others, who instead noted the incompatibility of European medicine for Indians.

It is somewhat surprising how little representation Unani receives in the Usman Report: two testimonies in English and two in Urdu from within the Madras Presidency, and a further two in English from outside the Presidency, with about ten *hakims* recorded as having given oral evidence. Volume 1, Appendix I, chapter 10 (pp. 87-96), “An Additional Note on the Unani System” provides a short summary of the history and principles of Unani. It is difficult to account for this lack of representation. Only few Unani testimonies seem to have been submitted to the committee. The report does not make clear whether the relative scarcity of testimonies for Unani reflected a proportional lack of existing Unani establishments and practitioners, or whether it was caused by the questionnaires not reaching Unani practitioners, or was due to Unani practitioners not taking the opportunity to respond.

The Usman Report does not fully capture the richness and diversity of remedies those seeking treatment for health in rural India might have encountered. However, there are some glimpses into this wider variety of medical treatment available. For example, there is a brief testimony from a masseuse and surgeon of boils who learned his skill from within the family (Usman Report, vol. 2: 466) as well as some mentions of astrology, mantra, and other forms of treatment (for astrology, see, for example, Usman Report, vol. 2: 251; for mantric practices, see vol. 2: 269).

The authors of the Usman Report argued that it was vital to harness the power of traditional medical practitioners to promote the general health of the Indian population, and a perceived need to establish and maintain institutions to teach and distribute indigenous medicine was central to the aims of the report. The framers of the enquiry hoped that by focusing on Ayurveda, Unani, and Siddha as more systematic and reputable systems of medicine, a more convincing argument for promoting and supporting indigenous traditions of medicine could be established.

That the indigenous traditions of India nevertheless continued to be held in disrepute by colonial bureaucratic and medical personnel throughout the colonial period was evidenced by the immediate reaction to the Usman Report as covered in *The Lancet* and the *British Medical Journal*, and repeated in the English-medium newspaper of Madras, *The Times of India*. The *British Medical Journal* asserted that:

The opinion is expressed in the report that no Western scientist should think of criticizing Ayurveda until he has learnt the Sanskrit language and studied the subject for some years under a competent Acharya. But the Western scientist has no need of any such prolonged and detailed study... In the last hundred years science has emerged from the metaphysical stage into the clear light of positive knowledge, and if the Madras Government has the interests of the Indian people genuinely at heart, it will expend its energies in planting modern science in the country, by the agency of scientists and teachers trained in Western methods, instead of endeavoring to stimulate the belated indigenous systems into renewed activity. (*BMJ* 1923: 477).

The Times of India opinion reasserted these British medical assessments of the Usman Report more directly as a failure: "One may as well try to put life in petrified bones of centuries, as to revivify these systems that are a mysterious compound of mantras and invocations, religion, metaphysics and speculative philosophy, with superstition and even prejudices superimposed upon all" (Choksy 1924).

Nevertheless, the Madras Presidency bowed to the force of public opinion, and the recommendations of the Usman Report to establish a government-sponsored training school were the first element of the recommendations to be accepted. After much debate, a government-funded School of Indian Medicine in Madras was formally sanctioned, with three sections in Ayurveda, Siddha, and Unani and a course extending over three years (Hausman 1996: 252).¹⁵ Two years later, facilities for both outpatients and inpatients were added and student intake was expanded to up to 120 to include training in both Indian and 'Western' systems of medicine:

The school is intended to provide such training to its alumni as will enable them to become competent practitioners of Indian systems of Medicine with a good working knowledge of the western system also. It is with this end in view that provision has been made in this School not only for the proper training of students in Ayurveda, Siddha and Unani but also for giving them courses of Instruction in such subjects like Modern Anatomy, Physiology and Surgery in all its branches including Midwifery and Ophthalmology. Provision has also been made as well for Herbarium, Museum Library etc. (Government Order No. 358, P.H. 2 March 1926, quoted in Kandaswamy Pillai 1979: 265)

¹⁵ Appendix VIII in volume 1 of the Usman Report lists the "Certain Schemes of Study of Indian Medicine" that were extant prior to this establishment (vol. 1, app. VIII: 117-134).

The first examiners were appointed in 1928. However, it was ten years after the Usman Report, in 1933, that there began to be established a register for qualified graduates of indigenous medicine (Hausmann 1996: 266-267).¹⁶ The vision and framework for establishing the systematic study of three Indian medicines, which was recommended in the Usman Report, remained the working framework for the study of Indian medicine in this institution until Congress took over administration of the Presidency in 1946, just prior to Indian Independence (Kandaswamy Pillai 1979: 564-567).

The medical anthropologist Charles Leslie concluded that “during the 1920s and 1930s [there was] trained a generation of practitioners who imagined a comprehensive national medical system that would be inspired by Ayurveda and that would assimilate cosmopolitan medicine to indigenous culture” (Leslie 1992: 179). In the years leading to independence, many nationalist leaders, both in and out of the Indian National Congress, continued to support various forms of *swadeshi* health promotion and healing. Mohandas Gandhi was better known for the championing of naturopathy as an accessible form of promoting health for rural populations (Alter 2000). Other nationalist figures, like Pandit Malaviya, founder of Banaras Hindu University, more directly supported a revival of Ayurveda and the healing potential of yoga practices (Newcombe 2017). The Usman Report was a key document in establishing such perception and in linking the provision of Indian healthcare for Indian bodies with the *swadeshi* and *swaraj* movements. It provides a remarkable opportunity for understanding regional similarities and variations in the understanding and practice of indigenous medicine in India’s late colonial period.

The very political framing of these debates continued throughout the twentieth century. The next major Indian government report, the Bhore Committee (1946), adopted a scathing attitude toward any scientific pretences of indigenous systems of medicine (see Wujastyk 2008: 11-20). Although after independence the Chopra Report (1948) again immediately tried to redress this accusation with more empirical data from contemporary practitioners, in many ways the frameworks of understanding and debate that continue to preoccupy supporters and critics of Ayurveda and other ingenious medicines today can be clearly seen as having been first articulated in the Usman Report. The richness of the Usman Report as a primary source to the diversity and shared preoccupations of front-line Indian medical professionals is only now beginning to be appreciated. Our translations of the vernacular submissions are an effort to expand the usefulness and accessibility of this extremely significant historical testimony.

¹⁶ The Madras Medical Registration Act of 1914 regulated those claiming to be qualified in the European medical profession.

Translation policies and remarks on the vernacular testimonies

The translations of the vernacular testimonies were commissioned by the Ayuryog project with the aim of highlighting the historical significance of the Usman Report and making it available to a wider audience.¹⁷ As noted above, one of the Usman Report's special features is its multilingualism: the testimonies it records were written in English, Sanskrit, Urdu, Tamil, Kannaḍa, Malayalam, Telugu, and Oriya, each using different scripts. Indeed, some of the testimonies use several languages and scripts. For example, the testimony by Hakim Syed Mustafa (vol. 2: 165-177), which is mainly written in Urdu, also contains Persian aphorisms, which the author left untranslated, as well as Arabic aphorisms, which he translated into Urdu. Several Dravidian-language testimonies on Ayurveda contain quotations from Sanskrit works, typically rendered into the main script of the testimony. Several testimonies also contain English vocabulary, sometimes long quotations, more often single terms. Here, some of the authors transliterated these words into the script they were using. In other cases, the authors used the Roman alphabet for English terms and quotations.

Sanskrit vocabulary (in Tamil script) also occurs in the Tamil testimonies where it is "tamilised," e.g. Sanskrit nouns are frequently transformed into Tamil verbs. This is probably in keeping with the older Tamil texts' usage of integrating Sanskrit terminology. One Sanskrit witness (in Devanāgarī script) also quotes from Tamil sources and uses Tamil script for this, visually marking the quotations as coming from a different tradition.

These different registers are conveyed in the English translations here in various ways. For example, Sabrina Dato, in her translation of Hakim Syed Mustafa's testimony, which contains several Persian and Arabic aphorisms as well as English loan words, has transliterated and italicised the English loan words. In the case of the Persian aphorisms, which were not translated by the author for his Urdu readership, she has given her own translation of the Persian, indicating this in the text by italicisation and including the Persian original in square brackets following the translation. In the case of the Arabic aphorisms, for which the author offered translations within the text, she has offered her English translation of the Urdu translation given by the author, again italicizing it to indicate it was originally written in a language other than Urdu, followed by the original Arabic in square brackets.

¹⁷ The full title of the research project is *Entangled Histories of Yoga, Ayurveda and Alchemy in South Asia*. The Ayuryog project was led by Dagmar Wujastyk at the University of Vienna and funded by the European Research Council under the Horizon 2020 programme (grant agreement no. 639363).

- (c) (1) செரிமாதை (அஜீரணம், குன்மம், அதிசாரம், கிராணி முதலிய இரப்பை கோய்கள் (Diseases of the stomach),
 (2) மேகவாத குலை (Rheumatism)
 (3) இலிங்கபுண், பிரமேகம், மேகப்பூன், உருப்புகளை அரிக்கும் புண், அரையாப்பு முதலியன (Syphilitic chancre),

مگر ہمارے آئنا بہتر ہے۔ دعوای سے کیا جاسکتا ہے۔ کہ جہاں انگریزی ڈاکٹر تھرو-امیڈر (thermometer) کے ذریعے بعض نوبات مریض کو بخار سے پاک کر کے دیتے ہیں وہیں ماہر دیسی طبیب با وجہن ٹھمبریور (temperature) نارمل (normal) سے کم پورہ کے بھی اس بات سے آگاہ پورے ہوجے۔ کہ مریض خطرناک بخار میں مبتلا ہے۔

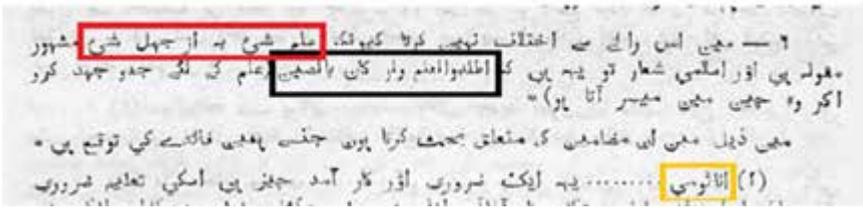
श्लेहनकफस्य स्थानं शिरः । सुश्रुतेनोक्तम् । शिरस्स्थानेहतर्पणाधिकृतत्वादिन्द्रियाणामामवोर्ये-
 गानुग्रहं करोति । श्लेहनकफभावे मस्तिष्कगतेन्द्रियकार्यं न भवति । पाश्चिमात्या अप्येवं वदन्ति—
 “ Its chief use is probably to afford mechanical protection to the nervous centres and to prevent
 the effects of concussions communicated from without.” Gray's Anatomy. श्लेषणकफस्य स्थानं

Examples of the integration of English terms and quotations in Roman script in Tamil, Urdu, and Sanskrit (Devanāgarī script) testimonies

अत्र गैर्वाण्या विद्यमानान् बहून् रसग्रन्थान् अपरांश्च आयुर्वेदग्रन्थान् स्वयमधीत्य तानेव
 द्वाविद्यां विवृण्वान् महामुनिरगस्त्य इति स्पष्टं समीहितमास्ते । “तेरेयर् श्लेरप्पा”
 (தேசையர் சேகரப்பர்) इतिग्रन्थस्य मङ्गलपद्यस्यानन्तरं किमपिहितमिति अवलोक्यतां भवद्भिरिव—
 “ தமிழின்புற வசனம் பெறு தனுவந்தரிவடனல்
 இயிரும்பத முழுதுகணி யெழுதும்படி. ஒருமே
 ஆமவன்பரை யருளுஞ்சுத ரருளுக்கு வரணும்
 தமசை புறு தயவுப்பிரி தகவுப்பொளசிவனே.”
 इत्येतेः अपरैश्च हेतुभिर्वलवद्भिः अस्ति वक्तव्यं, नास्ति किमपि तन्त्रान्तरं नाम्ना “सिद्धवैद्यम्”
 इति । परं च केवलमिदं कादपिनकं अव्यवहतपूर्वं च शब्दमात्रपर्यवसायि नाम ।]

Tamil quotations in Sanskrit (Devanāgarī) text

For the Sanskrit portion, one of the translators (Vinoth M.) has opted to transliterate Sanskrit verses that were identifiably quotations from the Ayurvedic classical treatises, providing the translation beneath. In a very few cases, the translators were unable to provide translations of verses or prose given in another script and/or language within one text. In those cases, images of the untranslated text are given in lieu of a translation.



Arabic, Persian, and English within an Urdu testimony. The yellow box highlights an English word that has been transcribed into Urdu. The black box highlights a well-known Arabic phrase attributed to the Prophet Muhammad which reads, “Seek knowledge, even if it is in China.” The red box highlights a Persian aphorism, which comments on the knowledge project of aligning the categories of biomedicine with classical Avicennian medicine.¹⁸

The testimonies in the Usman Report concern specialist medical knowledge, and therefore, particularly in the answers to the questions about the theories of the medical system, our translators were confronted with many specialist technical terms, but also quite often with poetic or even encrypted language. The latter is especially true for the Tamil sources. Since the report was written in the early 1920s, some of the era’s assumptions about medicine are reflected in the vocabulary used, leading to a certain ambiguity with regard to the meaning of terms. In the English-language testimonies, we find reference to modern disease categories, such as typhoid, leprosy, and diabetes. However, equivalences in vernacular languages are seldom given (there is, for example, one instance of leprosy being equated with the Ayurvedic disease category of *kuṣṭha* on page 3). Nevertheless, we are aware that the indigenous practitioners may very well have had modern disease categories in mind even when using traditional vernacular vocabulary, something that is ubiquitous in modern discourses on Ayurveda, Unani, and Siddha.¹⁹ We have, however, typically opted to use more conservative translations for technical terms, such as “consumption” for *kṣayaroga*, or “respiratory disease” for *śvāsaroga*, etc. Similarly, the translation of technical terms used to describe the physical and mental processes involved in the causing of health and disease presents a set of difficulties, as their translation into a single term does not fully convey their meaning. For example, historical and philological studies on Indian medicine often use the term “humour” for the Sanskrit term *doṣa*, as there are strong parallels, if also significant differences, between the *doṣa* theory and the

¹⁸ We would like to thank Sabrina Dattoo, who highlighted the Persian, Arabic, and English sections and provided explanations of their content.

¹⁹ On the subject of equating old categories with modern biomedical terms, see Meulenbeld 2008.

Greek humoral system. Ayurvedic theory usually speaks of three *doṣas*, called *vāta* or *vāyu*; *pitta*; and *kapha* or *śleśman*. These are often translated with wind, bile (or cholera), and phlegm, respectively, again in parallel with the terms used for similar entities in Greek medicine. This is the translation that we have applied throughout. However, it should be noted that, in the English part of the testimonies, several authors emphatically reject this usage, sometimes offering alternative translations or glosses, sometimes simply leaving the terms untranslated: There is no standard rendering of the terms.²⁰ The main translator of the Sanskrit portions of the Usman Report, Dr Trupti Patil-Bhole, who is a certified doctor of Ayurveda, concurs in rejecting the usage of “bile” for *pitta*, and “wind” for *vāta*, preferring to leave the terms untranslated, or translated as “fire element” and “air element”, respectively. For consistency, we have nevertheless applied the former translations throughout, keeping in mind that these are approximate renderings that do not fully represent the semantic field of the original terms.²¹ We have added a note to Dr Patil-Bhole’s translations, as her view represents a common perspective of current ayurvedic practice.

In the translations, technical terms for physiological or other principles that are specific to the indigenous medical traditions are rendered into English and followed by the vernacular term in round brackets. Square brackets indicate an explanatory addition by the translators or editors. All footnotes are also additions by the translators and editors.

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²⁰ For example, Hara Chandra Chakrawarthy (UR, vol. 2: 20) translates *vāta*, *pitta*, and *kapha* as vital current, metabolic fluid, and lymph, respectively. Hariranjana Majumder (UR, vol.2: 56) uses the term humour, but glosses *vāta*, *pitta*, and *kapha* with wind, heat, and cold. See also the reference to the interpretations of C.V. Subramania Sastri mentioned above.

²¹ See Wujastyk 2002: xlii-xliii for a discussion on how these terms have historically been translated and how interpretations of them changed over time in different historical and political contexts. The explanations in the testimonies also give good introductions to the subtleties and complexities of these and other fundamental concepts.

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