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Towards "Revolutionary Medicine"

Examining Western medicine as a colonial tool

This article explores how the field of medicine transformed societal values during the British colonial era, and how it continues to do so by asserting a Eurocentric view of medicine in former colonies. Based on Samir Amin's claim that intrinsic to the accumulation of profit in empire was the rapid expansion of capitalism within the colonies (1990), I argue that the institution of capitalist relations in British India from the 18th to the 20th century relied heavily on the imposition of Western medicine. The continuing encroachment of these capitalist relationships in the post-colonial era prevents the revival of indigenous medicine and can be classified as a form of neocolonialism. I employ a plurality of theoretical frameworks from various political theorists—namely Federici, Robinson, Quijano, and Harvey—to demonstrate how Western medicine transformed ecological and social relations within the Indian subcontinent to service Britain's colonial project. Through the use of each framework as a basis of analysis, I discuss how Western medicine altered gender and environmental relations and created new ones centred on race. I show how these altered relations served the underlying colonial project in British India. Finally, I explicate how neocolonial forces, by disrupting ecological relations, have prevented the resurgence of indigenous medicine post-partition. The institutionalization of the specific social and ecological relations necessary to colonialism, and more broadly to capitalism, in the subcontinent were implemented, in part, through Western Medicine.

Keywords: Colonialism, neocolonialism, Western medicine, indigenous medicine, colonial India

In this article, I explore how the seemingly apolitical field of medicine transformed societal values during the colonial era and how that move continues to perpetuate a Eurocentric view of medicine in former colonies. I situate my work within critical medical anthropology (CMA) which addresses the historically specific (re)production of dominant cultural constructions of health while remaining attendant to structures

of power such as capitalism (Singer & Baer, 2011). I deploy a neo-Marxian political-economic approach which elucidates the influence of governance on generating inequality within numerous aspects of society, including health. In so doing, I aim to show the dominant role of capitalism in generating health inequality within former colonies and propose that health policy must remain attendant to these factors to produce, in Che Guevara's words, revolutionary medicine.

My argument begins with an overview of Western medicine and pre-colonial indigenous medicine as the basis for subsequent content. Western medicine altered existing social, namely gender and ecological relations, and introduced new social relations based on race. These altered relations served the underlying colonial project in British India. Ultimately, I show how neocolonial forces have further interrupted ecological relations and hindered the resurgence of indigenous medicine post-partition. Based on Samir Amin's claim that intrinsic to the accumulation of wealth in the colonial empire was the rapid expansion of *capitalism* within the colonies (1990), I argue that Western medicine was used as one means of colonization during *the imposition of capitalist relationships* in British India from the 18th to the 20th century. Additionally, the continual imposition of capitalism in the post-colonial era hinders the revival of indigenous medicine and constitutes neocolonialism.

Colonialism is an economic project contingent on the material and psychological exploitation of a native population and lands for the benefit of the colonial state serving the demands of capitalism. The underlying mission of colonialism is the continual expropriation of capital from indigenous people for colonizers *through the imposition of capitalist relations*. In this article, the term capitalist relations references gender, racial, and ecological relations subservient to capitalism's goal of endless wealth accumulation.

MEDICINAL FORMS

The hospital and the laboratory are the features that define Western medicine (Cunningham & Andrews, 1997). The institution of the hospital is associated with a clinical setting that seeks to correlate the symptoms of patients with bodily changes for treatment. Additionally, hospitals are the epicentre of bodily invasion for which surgeries and technology are primarily responsible. Conversely, laboratories are where the causes of diseases are determined and cures are sought, in accordance with the scientific method (Cunningham & Andrews, 1997). Therefore, colonial medicine is generally reductionist in its methodology and often contingent upon the division of the body into isolated parts. Henceforth the terms colonial medicine and Western medicine will refer to British practices within both Britain and India during the colonial occupation of the Indian subcontinent here dated from 1757, the start of the British East India company rule, to partition in 1947.

While numerous forms of indigenous medicine exist throughout the subcontinent, two widely practiced forms, Ayurveda and Unani, will be considered here. Despite the religious differences, with each form practiced by Hindus and Muslims respectively, major similarities exist between them and, prior to colonialism, both *vaidyas*, practitioners of Ayurveda, and *hakims*, practitioners of Unani, worked side by side (Panikkar, 2007). Both practiced within communal settings and utilized a holistic method of diagnosis. Furthermore, indigenous medicine emphasizes diet as the pillar of health and its pharmacology relies heavily on ingredients endemic to the local environment, particularly native plants and wildlife (World Health Organization, 2010). The relationship between human health and the environment is exemplified by the Unani principle *al-asbab al-sitta al-dharuriya* which states that a prerequisite for the health of the body is the health of the ecological surroundings (World Health Organization, 2010). Given the similarities and historical evidence that suggests Ayurvedic and Unani medicine complemented each other (Panikkar, 2007), my use of the term indigenous medicine will reference both forms.

INSTITUTION OF CAPITALIST RELATIONS THROUGH WESTERN MEDICINE

Gender

In my analysis, I do not seek to deny pre-colonial patriarchy but to assert that colonial medicine profoundly changed the character of patriarchal oppression in British India to serve the underlying colonial mission—the imposition of capitalism and its social relations. Of value to this analysis is Marx's conception of primitive accumulation; Marx argues that pre-capitalist economic formations led to structures intrinsic to capitalist accumulation and eventually capitalism (Marx, 1967). Federici, a Marxist feminist and pioneer of social reproduction theory, shows how women's household labour reproduces the male labourer, who sells his labour to capital, therefore reproducing capitalism. She expands Marx's understanding of primitive accumulation to address the systemic oppression women face under capitalism. Federici (2014) outlines three conditions of primitive accumulation, all relevant to the case of colonial medicine:

> (i) the development of a new sexual division of labor subjugating women's labor and women's reproductive function to the reproduction of the work-force; (ii) the construction of a new patriarchal order, based upon the exclusion of women from waged work and their subordination to men; (iii) the mechanization of the proletarian body and its transformation, in the case of women, into a machine for the production of new workers. (p. 12)

For Federici, the removal of 16th-century European women from their female midwife-assisted communal birth settings and their relocation to hospitals where they were subjected to a male doctor's authority provided a case in point. This move

served capitalism's need to produce new workers, as male doctors ensured women were not committing infanticide during population shortages (Federici, 2014). The need for the worker—a child—preceded any concern over the woman's health—her body reduced to "a machine for the production of new workers" (Federici, 2014, p. 12). Capitalism's reliance on labour-power, even in its embryonic form, was inextricably linked with patriarchal oppression and lent itself to the creation of a singular system of patriarchal capitalism.[1] The shift in the control over the birthing process demonstrates a parallel between the experiences of European and Indian women satisfying Federici's third condition of primitive accumulation. In pre-colonial India *dais* (midwives) and women within the family were all present during the home birthing process; the British argument that hospitals, a pillar of Western medicine, better serviced women's needs disrupted the tradition. Though the pro-hospital argument has some validity, represented by the fact that three out of 20 women died in the home birthing process (Samanta, 2014), the statistic is not direct evidence of the relative inefficacy of indigenous medicine, as it was purported to represent. The primary reason for the high mortality rates was a lack of training in indigenous medicine afforded to lower-caste *dais* (Samanta, 2014). Nevertheless, hospital birthing with British male doctors was forced upon local women to ensure a higher survival rate of indigenous labour which supported the colonial project.

Accompanying the rise of hospital births and British concern for women's health (read production of labour) was a new colonial conception of motherhood instituted through the dissemination of a slew of literature authored by British doctors. The literature recommended pregnant women should not engage in any labour, and that other women take over household duties, a stark contrast to pre-colonial values where pregnant women continued to work (Samanta, 2014). This ban subjugated women's labour, in this case labour during gestation and birthing, to the reproduction of the workforce. While women in pre-colonial India were involved in a sexual division of labour, this division—under colonialism—began to service the reproduction of labour for capitalism. These normative directives created a new sexual division of labour, leading to the subjugation of women's bodies' labour to the reproduction of the workforce: the first principle of primitive accumulation.

Though women in pre-colonial India were mostly relegated to work for the household, this sphere encompassed a plurality of tasks that extended far beyond a reproductive role. Indeed, Ramaswamy (2010) notes that women commonly worked such diverse tasks as oil extraction for cooking and farming. This is in sharp contrast to the "new" definition of women as prescribed by hospital literature, which confined women to a much narrower definition of the household. The literature defines the wife as subservient to men and assigned to unpaid European Victorian-era household

[1] The term patriarchal capitalism will be used throughout this paper for the purposes of distinguishing indigenous patriarchy from capitalist patriarchy though Federici does not address this distinction.

tasks (Samanta, 2014). In contrast, though many women were confined to the household within pre-colonial India, this did not assume an exclusion from paid labour (Ramaswamy, 2010). Therefore, a new patriarchal order where women were excluded from paid labour was made possible by Western medicine's "new" expectations of an Indian woman: one which confined her knowledge and now unpaid labour to an ever-shrinking definition of the household, satisfying the second condition of primitive accumulation.

Race

Unlike patriarchy, white supremacy did not exist in pre-colonial India. Cedric Robinson (1983), a critic of orthodox Marxism's neglect of race, introduced the notion of racial capitalism—the conception that primitive accumulation in Western Europe was contingent on the racialization and racial exploitation of the intra-European population with the object of racial exploitation changing over time from the Irish to Slavs, etc. Therefore, racialization and racial exploitation were intrinsic to the process of capitalist accumulation *within* Europe. Notably, due to capitalism's constant need for new markets, this racialization took on an inter-continental outlook during the era of colonialism and reduced the need for intra-European subjugation. As part of that move, the British colonial project introduced racial capitalism into British India, which was contingent on *the racialization of the indigenous population*. The methods by which racialization occurred can be understood using the concepts of knowledge perspective and coloniality of power as posited by Aníbal Quijano—a Peruvian decolonial Marxist scholar whose work has implications for the Indian context.

Quijano's (2000) concept of knowledge perspective articulates the racial bias associated with the superiority afforded to Western thought, consistent with the introduction of a racial hierarchy within the field of medicine in the subcontinent. This move is emphasized by Bengali obstetrician, Dr. Kedarnath Das, who spent twelve years redesigning British forceps, a surgical instrument utilized during births, to meet the specifications of the average Bengali woman's physicality only to have his achievement dismissed by British doctors on the grounds that "a man . . . cannot carry about with him a number of forceps" (Samanta, 2014, p. 123). Here, Das's assimilation into Western medicine was not enough: this critical examination of Western thought or fusion with indigenous knowledge by an Indian was thought to be inferior, or even a rebuke. Similarly, in 1909 the Indian government's proposal to open superior positions to Indians in medicine was met with swift condemnation from the Indian Medical Service (IMS) (Kumar, 1997). One IMS surgeon went so far as to state that "moral stamina, self-reliance, and self-confidence are not yet ripe for the Indian [who] . . . falls back upon the primitive and prehistoric treatments [indigenous medicine]" (Abbot, 1908, as cited in Kumar, 1997, p. 179)—a comment was made in reference to Indians who had been trained in Western medicine in

Europe. Not only was Western medicine upheld as the gold standard, but any attainment of Western knowledge by Indians was met with the suspicion of "regressing" to an inferior (read indigenous) mode of reasoning. An example of the paternalistic attitude associated with the assumption that Western medicine would "fix" the indigenous population's health is Queen Victoria's declaration, upon receiving reports of Indian birthing practices, that "something must be done for the poor creatures" (Samanta, 2014, p. 112). Each of these examples reinforces that the introduction of racial hierarchy is paralleled by an emphasis on the superiority of Western medicine.

The coloniality of power, as conceived by Quijano (2000), is a "pattern of world-power" (p. 218) dependent on racial classification expressed through a plurality of forms. Two of these are the distribution of work and the privileging of "Whiteness" as it pertains to salary (Quijano, 2000). The new distribution of work within the subcontinent was expressed through the professionalization of Western medicine and the concomitant undermining of indigenous medicine. As medicine became increasingly associated with care in the hospital, the abode of Western medicine, it became more difficult for the indigenous population to obtain medical certification because of the European university requirement. The distribution of medical work thereby shifted, and complaints were made by indigenous doctors about the lack of higher rank and salaried positions given to indigenous doctors (Kumar, 1997), indicative of systemic discrimination. While there were limited numbers of European doctors in India, given that the Indian population greatly outnumbered the few settlers, within the upper ranks of the IMS, European doctors were a majority presence. Indeed, one Indian doctor explicitly noted that one often finds Indians relegated to lower positions whilst less qualified European doctors ascended the ranks (Kumar, 1997). This double movement within the ranks and redistribution of work through racial bias is evident and led to the widespread understanding among Indian doctors that "Whiteness" translated to higher paying positions.

Nature

Adding to colonial change, Western medicine's view of nature was consistent with the Enlightenment era's conception that nature was something to be conquered. The aggressive language deployed by Western doctors when they declared war on a host of diseases (Lee, 1997) that involved insects—creatures of nature—is just one example. In contrast, an understanding of the mutually beneficial relationships between all beings is clear within the Unani principle *al-asbab al-sitta al-dharuriya,* whereby human health is contingent on the health of the earth. Suppressing indigenous medicine led to severing the pre-colonial relationship to nature and replacing it with Western medicine's agonistic worldview.

The defilement of indigenous medicine was further instituted through the Indian state apparatus, which catered to the forces of primitive accumulation. The forces of

primitive accumulation are contingent upon a conception of the state as having a monopoly over the meanings of legality (Harvey, 2003). In this way, the decline of the indigenous relationship with nature was amplified through the Indian legislation's *restrictions* on indigenous medicine. This move indirectly promoted the status of Western medicine, furthered by the lack of funding allocated to indigenous medicine by the Indian state. A clear example is the 1822 Indian government's rejection of legislation giving indigenous doctors the same rights as doctors practicing Western medicine (Kumar, 1997). Indigenous medicine was dealt another blow in 1912 when the Registration Act barred any state patronage of indigenous medicine. Although extensive lobbying prompted the Indian state to open a few indigenous medical colleges in 1916 (Kumar, 1997), this measure of reform proved to be ineffective as most of these colleges no longer exist. Overwhelmingly, legislation led to a weakening relationship between Indians and nature including the severance of the pre-colonial insistence on a harmonious relationship.

NEOCOLONIALISM IS PREVENTING THE RISE OF INDIGENOUS MEDICINE

Moving out of history and into the current context, neocolonialism continues the underlying mission of colonialism: the proliferation of capitalist relations. Neocolonialism, however, takes into account the shift in global power balance between the colonial times Britain-dominated world order and present-day American hegemonic influences. Which nation perpetuates these relationships is inconsequential, as it is the proliferation of capitalist relations within the subcontinent that prevents the resurgence of indigenous medicine and *deepens the reliance on Western medicine*. Overall, environmental capitalist relations persist and prevent the rise of indigenous medicine.

Many who argue that indigenous medicine has been embraced in the "post"-colonial era point to the World Health Organization's (WHO) implementation of the Alma Ata declaration in 1978, which formally articulated an indigenous-inclusive definition of healthcare—albeit only in the primary healthcare sector (Lee, 1997). Failure to meet the progress markers of Alma Ata, namely the Millennium Development Goals and the Health for All initiative by 2000 (Walley, 2008), demonstrates a lack of indigenous medicine resurgence, despite the WHO push. I assert that the inability to revive indigenous medicine is a consequence of the exogenous influence of capitalist America in continuing to shape environmental relations in post-partition India.

The link between the degradation of the environment and the inability to practice indigenous medicine is encapsulated by Indian environmental scholar-activist Vandana Shiva's (2018) statement that "there is an intimate connection between the soil, plants, our gut and brain." If there is an inability to produce food that is free of pesticides, then there is an inability for indigenous medicine to be practiced as it relies heavily on the surrounding ecological conditions. Shiva articulates how

American influence has promoted technological interference in post-colonial India's agriculture during the so-called Green revolution starting from the 1950s. The Green revolution was a shift to monocrop agriculture made possible by the heavy reliance on foreign agents such as pesticides. Shiva (2015) notes, "advisors and experts came from America to shift India's agricultural research and agricultural policy from an indigenous and ecological model to an exogenous and high-input one" (p. 22). The American agricultural agenda in India was insistent on the import of foreign seeds and fertilizers as integral to the mass production of food, creating Indian dependence on America. The World Bank and American government were heavily involved in creating this dependent relationship leading to the mass production and export of crops from India to the Global North at the expense of India's environment. Note here *the imposition of capitalist values* as it pertains to the environment in India. The American plan was contingent on the domination of nature, which is antithetical to the Indian agricultural notion of a partnership between the people and land. This coerced adoption of American agricultural methods and its associated value-system constitutes a significant dimension of neocolonialism. The adverse effects on the Indian environment were realized much later coinciding with the WHO's promotion of indigenous medicine. Given that indigenous medicine is reliant on contaminant-free soil and local plants for pharmacology, the so-called Green revolution prevented its revitalization through the reassertion of Western ecological relations. This "revolution," an American neocolonial project, which Indian farmers assert was responsible for the degradation of the soil and more broadly, for "the decline in the strength of the land" (Saha, 2013, p. 216) severely hindered the resurgence of indigenous medicine in the post-colonial era.

The institutionalization in the subcontinent of specific social and ecological relations necessary to colonialism, and more broadly to capitalism, began its gradual incursion, in part, with the introduction of Western Medicine. Through newly introduced gender relations, women were removed from their gender-exclusive communal birthing process and transplanted into male-dominated hospitals. This transition gave rise to a host of new economic relations based on the relegation of women into a much narrower definition of the household in which the reproduction of the workforce depended on women's unpaid labour. My examination of racial capitalism demonstrates how the racialization of indigenous people was necessary for British colonial control. Western medicine placed white doctors at the top of the pay grade and placed Western thought as racially and culturally superior to indigenous medicine. The severance of the harmonious relationship between Indians and the earth was furthered by an Indian state that supported capitalist expansion. Moreover, American capitalism orchestrated and expanded colonial relationships in the so-called post-colonial era, preventing the re-emergence of indigenous medicine. My article reveals how Western medicine contributed directly to the historical destruction of pre-colonial relationships between people and their environment and

to the perpetuation of the colonial project. Today, this continued interference hinders the recovery and reinstitution of indigenous medical epistemologies and practices in areas that need it the most.

Western Medicine, through colonialism, (re)produces patriarchal capitalism, racial capitalism, and ecological extractivism—maintained today by neocolonial intrusions within former colonies. The inefficacy of Western Medicine in the rural Global South is well-documented: Kumar et al. (2014) show that "in a country like India, where physical distance to health facilities is quite large in rural areas, access is a significant barrier" (p. 4101) to reaching a hospital—the Western centre for care. Subversion of indigenous medicine then moves beyond epistemological injustices and into life-or-death consequences, especially for rural people. The reluctance of mainstream health-policy discourse to engage with pluralistic, historically specific definitions of well-being along with the global structures of power installed during colonialism and reproduced today leads to band-aid reformist solutions. These measures seek to address the *effects* of global inequality manifested in Western healthcare instead of getting to the *causes* of inequality. By engaging with the role medicine played in colonialism and the creation of global inequality, I have historicized the root causes of health inequity. I suggest a path towards revolutionary medicine where the necessity for medicine to combat the effects of global inequity no longer exists. Revolutionary medicine, however, can only be realized once the structures of power that produce inequity are dismantled; and for this to happen, we must recognize colonialism's origins and its effects on the practice of medicine. It is my hope that this article offers a step forward on a path that leads us away from band-aid colonial solutions and towards a "revolutionary medicine."

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