

WESTERN AND AYURVEDIC SYSTEMS OF MEDICINE IN SRI LANKA: SOME PRELIMINARY OBSERVATIONS

S.T. Hettige

*Department of Sociology,
University of Colombo, Sri Lanka*

Abstract

Introduction of Western medicine to Sri Lanka resulted in the marginalization of Ayurveda which was the mainstay of traditional empirical medicine among the Sinhalese. In spite of the emergence of a vibrant Sinhalese-Buddhist nationalist movement in the late 19th century in opposition to the erosion of traditional values and institutions such as Buddhism and Ayurvedic medicine, the dominance of the Westernized, propertied and professional elite could not be checked. Introduction of democratic institutions and subsequent political independence, however allowed marginalized native groups such as Ayurvedic physicians to come forward and win certain privileges which were hitherto denied to them. Even though the events have not reversed the historical trend, they have nevertheless been significant developments with implications for the present and future position of Ayurveda within the healthcare system of Sri Lanka.

Introduction

AS it is already documented by Medical Anthropologists and others, the implications of the introduction of Western medicine into non-Western societies of Asia, Africa and Latin America have been far reaching (eg. Foster: 1973, Landy: 1974 Wolff: 1965, Leslie: 1977, Keswani: 1969, Huard: 1969, Logan: 1973). Even though the newly introduced system has not replaced the pre-existing systems and practices altogether, it has at least become a major source of health-care in most countries. If not for the fact that many people in these societies have limited or no access to Western doctors, particularly in the rural areas, utilization of Western medicine would have reached a much higher level than what it is today. This is in spite of the fact that many people continue to subscribe to some or all of the ideas and concepts associated with indigenous healing practices.

Sri Lanka, having been subjected to Western colonial rule extending over a period of about four and a half centuries, emerged as a politically independent nation state towards the end of the first half of the present century. Before colonial subjugation, it had possessed an elaborate system of traditional medicine and ritual healing practices. The result of the introduction of Western medicine during the colonial period has broadly conformed to the general pattern outlined above. The process of acculturation involved has been in keeping with the broader processes of social, economic, political and ideological changes that have ensued.

The objective of the present paper is to focus attention on the interface between the newly introduced Western system of medicine and the pre-existing Ayurvedic system in Sri Lanka. The main questions raised, and attempted to answer, are: (a) how did the new system influence the native system, (b) what was the outcome of this influence, (c) what were the forces that mediated between the two and finally, what are the implications of this influence for the future. Before an attempt is made to deal with these questions, it seems necessary to provide a background to this discussion at the outset. This will be done in the next two sections. In the section that immediately follows, a general introduction to the pre-colonial system of medicine and healing in the country is given, followed by a brief account of the processes of social, economic, political and ideological changes in the next section. The last section of the paper will be devoted for examining the questions raised above.

Since Sri Lanka is a multi-ethnic, multi-religious society, variations across such boundaries are only to be expected. While it is not denied that there exist significant commonalities between different ethno-religious groups based on such criteria as historical affinities, social class and education, it is nevertheless necessary to confine to a broadly defined community for convenience of analysis. In the present paper, focus is on the Sinhalese villagers in the south-western region of Sri Lanka. Due to its general nature, the discussion does not relate to a single village, though much of the key informant interviews and observations were conducted in two Sinhalese villages in the region from where the other general qualitative data was gathered during 1986. One of the localities involved is in the District of Galle in southern Sri Lanka, located about 12 miles to the south-east of Galle town and consists of small-holding producers of rice, garden crops and cash crops such as tea. This village, though located at a daily commutable distance from a major township, is still very much in the periphery in terms of basic amenities such as electricity, educational and health facilities. The second village, located about 14 miles to the south of Colombo, is urbanized and occupies an intermediate position. While most of the inhabitants here depend on non-agricultural sources of living, many of them commute daily to Colombo for salary, wage and informal sector employment.

Since the discussion that follows is pitched at a very general level, no reference will be made to these specific locations in the text. Moreover, it should be noted that the analysis itself is not more than a set of preliminary observations aimed at clearing the ground for more focussed and detailed studies based on intensive ethnographic research.

Pre-Colonial System of Medicine and Healing in Sri Lanka

The term "pre-colonial" is obviously too broad. So, admittedly, it does not refer to a clearly defined historical period. Nevertheless, since it

refers to the time preceding the period of colonial rule, it allows us to focus attention on the situation that prevailed before the introduction of Western medicine. On the other hand, our knowledge and understanding of the pre-colonial systems of medicine and healing practices in Sri Lanka are so limited that we could only identify their general features, largely by piecing together the diverse elements derived from the observations of the contemporary practice. This is an attempt not dissimilar to what ethnographers often do in their studies of "primitive" societies.

Pre-colonial society of Sri Lanka had no doubt been in a "melting pot" situation ever since the ancestors of its major ethnic and caste groups landed in the island, some of them at least several centuries prior to the dawn of the Christian era. The island's strategic location in the Indian ocean, on the sea routes connecting the Far East with West Asia and Europe, and its close proximity to Indian subcontinent, just 20 miles separating the two countries at the narrowest point, have kept the country open to outsiders, ranging from friendly visitors to ruthless invaders. This appears to have been the pattern for over thousand years before the arrival of Europeans in the early sixteenth century. These pre-colonial, external influences, though did not prevent the development of a unique civilization there with its distinctive features; nevertheless continually infused many imported elements into the local socio-cultural system. The systems of medicine and healing were not immune to these continuing influences. In other words, the development of the local system would have been a cumulative process resulting in the absorption of new elements. What seems to have been the main components of the pre-colonial system of medicine and healing?

As far as the author is aware, there exist no studies which have attempted to draw a comprehensive picture of the pre-colonial situation based on detailed historical data. Many contemporary researchers however have attempted to piece together the elements of traditional practices which have not only existed in the past but persisted into the present times. What is attempted below is to present this traditional system in a schematic form. (see Figure 1)

As is evident, traditional healing practices were not based on a single theory of disease causation, for different healing modes resorted to were based on diverse ideas, concepts and beliefs. If contemporary practice is indicative of the state of affairs in the past at all, the same person or family might have resorted to diverse practices over a period of time, depending on the contingency, though at least some of the concepts and ideas involved might have been in conflict with each other. Yet this would not have posed a major problem as the diverse practices corresponded to different aspects of the Sinhalese - Buddhist cosmological order in reference to which illness behaviour was fashioned.

In other words, different responses to illness corresponded to different facets of the cosmological order. If illness and misfortune are caused by divergent forces, it is only "rational" to resort to multiple sources of relief.

Diverse sources of influence identified in Figure 2 can be divided into two broad categories, namely, supernatural and [empirical]. In the sphere of the empirical, there is explicit recognition of "natural" causes of illness and of the capacity of "physicians" in curing or managing such illnesses. As far as illnesses "caused" by supernatural forces are concerned, healing or curing requires the intervention of supernatural and/or secret powers or people with magical or mediating powers. So, if an illness is perceived by the afflicted to be due to natural causes, then the tendency is to seek an empirical solution. Such illnesses may be divided into at least three categories: (a) illnesses defined in terms of humoural theory, i.e. *tun dos*, (b) disorders caused by external elements such as poisons, venoms and other toxic substances and (c) accidental injuries such as cuts, burns, fractures and bruises. There are in fact many native medical practitioners who are "specialists" in one or the other of these three areas.¹

Even in the above cases, it is not altogether unlikely that the afflicted or their close ones look for a "hidden" cause, but it is unlikely that they would then be prevented from seeking an empirical remedies. Rather what is more likely under such ambivalent situations is to seek redress from more than one source simultaneously.

As Figure 2 shows, illnesses and misfortune are also attributed to numerous supernatural forces. Such forces may range from highly abstract *loka dharma* through actions or influences of various malevolent and punitive spiritual beings to fellow human beings evil influences.

The existence of a notion of multiple causation of illness and misfortune presents the afflicted with numerous possibilities for action in order to deal with the situation. This makes the attribution of causes and the subsequent action dependent on many situational factors. In general, there are three possible courses of action open to the afflicted party; (a) resort to an empirical solution, (b) resort to a supernatural or a magical solution and (c) resort to multiple solutions.

Those who resort to an empirical solution, if later find the solution opted out for to be inefficacious, may then explore other possible solutions,

1 While *veda rala* or *veda mahattaya* usually deals with illnesses defined in terms of humoural theory, *visha veda* and *kadum-bindum veda* deal with categories (b) and (c) respectively. Sinhala word *Visha* in this case refers mainly to snake venom. And the term *kadum-bindum* refers to bone fractures.

Figure 1: Sinhalese System of Healing and Medicine

Conceptual Framework	Practices	Underlying Ideas, Concepts	Agents involved
Religion/ Ritual	Religious Rituals: pirith	Secred Powers of Dhamma	Monks
	Exorcism Rituals	Destruc. Powers of Demons	Exorcist
	Propitiation of Deities	Punitive/Benevolent Qualities	Kapurala
	Propitiation of Planets	Positive/Negative Effects	Bali Adura
Magical	Sorcery/Evil Persons	Magical Power of Sorcerer Objects, Words, etc.	Sorcerer
	Apeal to Supernatural Agents (Malevolent)	Destruc. Powers of Deities	Kapurala
Empirical	Indigenous Medicine	Humoural Theory of illness	Native Physician
	Western Medicine	Medical/Biological Sciences	W.Doctor

Figure 2: Sources of Influence on Health and Well-being

Source	Form of Expression	Source of Relief
Loka Dharma	Karma	Good Conduct
Nature	Humours	Right Life/Medicine
Planets	Unfavourable Periods	Merit/Benevolent Gods
Gods	Protection/Punishment	Propitiation of Gods
Goblins/Demons	Gaze / Attack/Possession	Propitiation/appeal to H/A
Black Magic	Sorcery (Huniyam/Vas)	Counter Sorcery
Evil Human Beings	Evil Eye/ word/thought	Ritual Protection
Prethas (Spirits)	Possession	Merit Transfer/ Exorcism
Toxic and Poisons	Poisoning/snake bites	Removal/treatment/ritual
Accidents	Fractures, Dislocations	Empirical Treatment

either still within the empirical field or outside it. Same pattern may apply those who first resort to a spiritual or a magical remedy. It should however be noted that, depending on their conviction, an afflicted party may remain within the same 'field', either supernatural or empirical, in finding a solution. For example, one may go from one ayurvedic practitioner to another, rather than from the former to an exorcist.

The already extensive ethnographic literature dealing with healing rituals among the Sinhalese (eg- Wirv: 1954, Ames: 1964, Obeyesekere, 1970, 1975b, Kapferer: 1983, Stirrat: 1977, Yalman: 1964) has overshadowed the widespread prevalence of empirical healing practices in Sinhalese villages. Before the introduction of Western medicine in the forms of dispensaries, hospitals, mobile clinics and grass-roots-level para-medical personnel, rural people had resorted to Ayurvedic and other forms of herbal remedies. Given the fact that Ayurveda which was introduced to Sri Lanka by the early immigrants from India had at best remained stagnant as a medical system for at least a few centuries preceding the dawn of Western colonial rule in the early 16th century, it is likely that the practitioners in the outlying rural areas, largely isolated from the "centres" of the profession, became parochial and less "influential" than their metropolitan counterparts. The conventional wisdom, which, often passed through family tradition from father to children, no doubt retained the basic tenets of Ayurveda, but the limited resources in small village hamlets in general would not have been conducive for local innovations and additions. So, whatever the developments that took place in the local tradition would have been confined to a few master physicians (*vedaduru*) who maintained a retinue of apprentices drawn from the vicinity. On the other hand, those who practiced Ayurvedic medicine in the remote villages would have been limited not only in terms of access to knowledge through interaction with their metropolitan counterparts but also the range of pharmaceuticals at their disposal. Even today, many practitioners in the outlying areas have at best an elementary knowledge of Ayurveda and prescribe only a very limited range of herbal remedies.

The diversity of early immigrants to Sri Lanka meant that they introduced, apart from Ayurveda, many other curing and healing practices. These included such empirical systems as *Yunani* or Greek medicine, based on arabic texts, *siddha*, a tradition based in south India and *homeopathy*. But the Sinhalese villagers do not necessarily distinguish between these different traditional systems, though they themselves may occasionally consult different practitioners, if the latter happen to be located in the vicinity. Nevertheless, for them, Ayurveda is the primary frame of reference as they themselves are familiar with the elementary ideas, concepts and the logic involved. Moreover, they themselves know a considerable number of herbal remedies and their basic "qualities".

They give expression to the humoral theory associated with Ayurveda in their daily conversations. As is well known, for them, Ayurveda also provides a framework for healthy behaviour and therefore, constitutes a set of principles guiding day-to-day conduct; eating, bathing, sleeping, etc. So, Ayurveda, for them, is not merely a curative system but a preventive one as well.

Ayurveda is also a system which allows a considerable degree of autonomy for the afflicted because the physician has no total monopoly over knowledge and action. For instance, the afflicted, under the guidance of their close ones, may try many home remedies before consulting a physician. Ayurveda is generally thought to be a way of life and a framework for remaining healthy and one has to consult a physician only when the illness is too complex to be comprehended by laymen and requires a specialist for diagnosis and treatment.

Since Ayurveda is at the centre of the empirical component of the traditional healing and curing system of the Sinhalese villagers, it seems to be useful to note the basic ideas embodied in it. However, no attempt is made here to examine them in detail as such detailed accounts can be found elsewhere (cf. Obeyesekere, 1976, 1977),

As mentioned before, Ayurvedic system is based on a humoral theory which virtually equates general health with a balance between 'the three humours' or *tun dos - va, pit, sem* (air, bile and phlegm respectively). So, by definition, any imbalance between the three humours constitutes the basis of illness. It appears that this imbalance itself is a product of many factors such as changes in the external environment (i.e. seasonal or day and night), specific bodily constitution of the individual and personal conduct and habits, in particular dietary habits. In other words, through a process of adjustment, the individual in general could avoid humoral imbalance and remain healthy. But, when the balance is disrupted, intervention is required to control or manage the humours involved in order to restore normal health. Various medicinal preparations prescribed to patients are in general intended to restore the equilibrium that has been disturbed. While most ailments are considered to be the result of the eruption of one or another of the three humours, eruption of all three at the same time (*tun dos kipeema*) is perceived as a serious situation which can even drive the afflicted "mad" (Obeyesekere 1977).

Villagers tend to classify food into Hot and Cold types but may go even beyond such a simple dichotomy and attribute specific humoral qualities to different varieties of food. In other words, it is assumed that certain food items promote one or another of the three humours. Such distinctions are made within broad categories of food such as vegetables, fruits, fish, meat, drinks and milk. Though the villagers are not able to fit every item of food neatly into one or the other category, there

is general agreement about many food items, particularly those which are generally consumed. So, there are Hot vegetables such as tomatoes, Hot fruits such as mango, Hot fish such as tuna, Hot milk such that of goats, Hot meat such as beef and hot drinks such as coriander. In each of these broad categories, there are varieties having other qualities. Moreover, different qualities could be neutralized or reinforced by other factors such as the season of the year, time of the day, bodily condition and the conduct of the individual, mode of preparation, etc.²

Familiarity and concern with a humoural theory does not mean that the villagers recognize the specific qualities of each and every food item they consume. As mentioned above, nor are they in a position to pin point the qualities of all medicinal plants or plant material used in Ayurvedic treatment. While this does not weaken the influence of the theory on the conduct of the people, it nevertheless points to the fact that everything cannot be reduced either to a simple dichotomy of Hot and Cold or to a three-fold *dosa* scheme, for such a situation would leave little room for innovation and adaptation. In fact, humoural theory seems to provide only a set of broad guidelines.

Specific cases which do not neatly fit into the general categories open up opportunities for experimentation and trial-and-error procedures in relation to both diagnosis and treatment. Moreover, if a therapist strictly follows the theory, he might not be able to get out of many complex situations which do not fit into the general scheme (Obeyesekere 1976). On the other hand, if one "finds" through trial and error methods effective ways of dealing with such situations, such procedures and remedies may eventually become standard procedures and remedies. It is also possible that the origins of such anomalous procedures and remedies could lie outside the system of humoural medicine. Once adopted for pragmatic reasons, they may co-exist with those which fit into the theory.

At the level of the ordinary villagers, anomalies can be as widespread. For instance, certain foods may not be classified in humoural terms at all. Moreover, there is no unanimity among them as to specific qualities of certain food items, medicinal plants or herbal substances. Furthermore, some remedies used may not be identified in keeping with the theory. Again, the anomalies are either the result of the adoption of remedies 'tested' or legitimated outside the humoural system or the outcome of a pragmatic trial and error procedure with little regard to humoural theory (Foster 1988). Thus, some herbal home remedies (*ath beheth*) used for a variety of minor ailments belong to this category, yet have become standard remedies over the years.

2. Villagers tend to translate these notions into practice in their day-to-day lives. For instance, excessively Hot food is often eaten with food items which are supposed to have the potential of neutralizing excessive heatiness (*giniyama*) of Hot food.

Social Change and Indigenous Medicine

So far, an attempt has been made to outline the main features of the empirical side of the traditional Sinhalese medical and healing system. This multifarious system was subjected to the modernizing forces during the long period of colonial rule in the country. As is well known, the south-western part of Sri Lanka was the region which was most affected by Western colonial occupation for it was in this region that colonial interests were concentrated for the longest period of time. For instance, the coastal areas, including the South West, were under colonial domination from the early 16th century, while the rest of the country could not be subjugated until 1815. It was in that year that the whole country became a crown colony of the British empire under a unitary administration.

Four and a half centuries long colonial occupation resulted in the transformation of the country's traditional order; its economy, polity, society and culture. This does not mean that Sri Lanka became another modern, developed society. Far from it. Like many areas of the ex-colonial, underdeveloped world, colonial rule created a peculiar social formation, a hybrid culture and a distorted political economy which found no parallel either in the pre-colonial world or in the industrialized West. This is not the occasion for a detailed examination of the impact of colonial rule in its diverse forms. What is relevant for us, however is to recognize that the introduction of Western medicine and its propagation during the later part of the British rule and thereafter had a significant impact on the illness behaviour of the country's population, particularly in the urban areas.

Though many people continued to resort to conventional curing and healing practices, the provision of basic healthcare facilities in the forms of dispensaries, mobile clinics, and hospitals persuaded them to rely on new remedies. Public health measures that were taken brought many new and old illnesses under control bringing infant and adult mortality rates down. Even though many rural areas were poorly served by modern medical institutions and personnel, the habit of going to hospital for many ailments, particularly critical ones, became an integral aspect of illness behaviour even in the rural areas. If anything at all, it was extreme poverty or lack of transport facilities which prevented rural people from going to hospitals in emergencies. In fact, the Out-Patient Departments of many government hospitals became crowded places where the poor people congregate daily seeking Western medical treatment. The new health facilities in general, no matter how basic they were, helped reduce the degree of uncertainty that the people were hitherto faced with in the sphere of health.

As far as Western medicine is concerned, what impressed the people most was not so much the curative powers of the trained physicians

as the impact of the public health measures.³ For one thing, there were not many qualified physicians in the country to enable all those who so desired to consult them. Even at the end of the British administration in 1948, there were not more than half a dozen trained Western doctors per 100,000 population (Peebles: 1981, 56-57). Since even these limited number was mostly concentrated in the urban areas, perhaps the only way that a villager could consult a Western doctor would have been to go to a public hospital in the nearest town. This they would have done under certain circumstances such as in the case of serious illnesses and emergencies.

The above state of affairs had several implications. Firstly, even the most ignorant villager could not remain totally ignorant of the newly introduced system of medicine. Secondly, it would not have taken a long time before the people realized the empirical validity of Western medicine, at least in relation to certain common ailments which were treated at public hospitals. Thirdly, many people, however had no easy access to Western therapies so the general tendency was often to rely on those at hand. Fourthly, being another empirical remedy, Western medicine was accommodated within the broader system of curing and healing as another option, without leading to any significant conflict of ideas and beliefs. Fifthly, to the degree that Western therapy was instrumental in relieving the burden of illness, the relative significance, role and social standing of conventional remedies and sources of relief would have been reduced. And, finally, at least to some degree, legitimacy and social esteem of the Western system would have been enhanced. Moreover, the superior social position of Western practitioners no doubt helped establish their authority and influence over the general population.

The social standing and the cultural role of Western medicine cannot be discussed solely in terms of its supposed relative merits within the general health-care system, for its introduction and propagation were linked to a wider politico-economic and socio-cultural process. In this regard, what mattered most was that Western medicine was not only another 'innovation' of the dominant colonial ruler but also constituted a growing source of wealth, influence and prestige for the upwardly mobile, well-to-do native families.

3. The drop in infant, maternal and general mortality rates since the turn of the century has been impressive. Infant mortality rate of 170 per 1000 live births recorded for 1900 had dropped to about 44 in 1977. Death rate had dropped from about 27 to about 7 during the same period. Maternal mortality rate had recorded a similar trend of decline. It had declined from about 27 in 1930 to about 1 per 1000 live births in 1977. Deaths caused by diseases such as T.B., Typhoid Fever, Dysentery and Malaria which were behind the highest number of deaths in the early 20th century constitute only a small proportion of all natural deaths today (Peebles, op. cit. 49-51).

Affluent social categories who made their money through various avenues opened up by the colonial state did not fail to use their newly acquired wealth to give their children a Western education enabling them to take up modern professions such as law and medicine (cf. De Silva: 1981, chap. 8, Roberts: 1979). Though they were not so much motivated by the income generating potential of these professions as the high social esteem associated with them, many not so affluent families who persuaded their children to take them up treated medical profession as a source of upward social mobility in terms of both wealth and prestige. Quite apart from the money they themselves could earn through private practice, those men who took to modern professions were also capable of acquiring wealth through the dowry system as the new rich families offered handsome dowries to attract them as bridegrooms for their daughters.⁴

The expanding public healthcare system in the country became a major source of white collar employment within the state sector. Government hospitals, dispensaries and clinics offered employment to a large number of men and women at various levels. The drug stores opened up in the towns constituted a significant area of investment for the growing merchant capital. Public health and primary health activities also involved a large number of employees ranging from health educators through sanitary inspectors to village-level para-medical workers.

All those who were associated with the Western health-care system tended to influence the general population in various ways. In their own villages, they were sources of information and even advice for their neighbours. At least some of them became strong proponents of Western medicine in their own habitats. Given the strong tendency among Sinhalese villagers to share information (and even misinformation) with their neighbours and kinsmen, Western medical workers in their midst no doubt became catalysts in promoting positive attitudes towards the new system. Their relatively superior social position among humble villagers no doubt facilitated their role. It should be noted that some of the workers who have access to medical supplies even maintain a small stock of commonly used medicine in their houses for their own use. It is not uncommon that they make such drugs available to their neighbours, close friends and relatives. These stocks usually include common pain-killers, first-aid material and tablets given for worm infestation in children.

4. A casual glance through the matrimonial columns of local news papers would reveal that Western medical doctors still occupy the highest position among professionals who attract highest dowries. In recent years, however, widespread tendency among University students to select their own partners appears to have reduced the significance of transfer of wealth through the dowry system to a considerable extent.

The high literacy rate in Sri Lanka achieved through free education, particularly since independence, has been another factor conducive for the development of favourable attitudes towards Western medicine. Those pupils who stay on for a few years in school are usually exposed to elementary ideas associated with Western medical science such as germ theory of disease, importance of personal hygiene and environmental sanitation, etc. Given the wide coverage of the education system in the country, it is reasonable to assume that schools have played an important role in promoting Western medicine. The process was no doubt further facilitated by the health education programmes involving a countrywide network of primary health workers. Health education films screened in the rural areas by mobile film units reached even the illiterates and propagated basic health messages throughout Sri Lanka.

Last but not least, the emergence of a westernized local elite subscribing to Western values and ideas further contributed to the devaluation of native institutions including indigenous healing and curing practices. For the members of this elite in general, the latter seemed to have appeared as pre-scientific, if not unscientific. Moreover, their interests lied not in the declining native economic, political and social structures but in the growing colonial economy and institutions such as plantations, bureaucracies, modern professions like medicine and political structures.⁵

Growth of a dominant, Westernized, elite, however did not prevent the emergence of nativistic movements. As is well known, a vibrant Sinhalese-Buddhist nationalist movement grew in Sri Lanka in the second half of the 19th century, in opposition to the continuing erosion of traditional socio-cultural values and the decline of native institutions under the influence of colonial rule. Though the movement's opposition to the Christian missionary activities highlighted its strong religious orientation, i.e. Buddhist, in rejecting the Western way of life in general, it nevertheless encompassed wider social values (De Silva, *op. cit.*, chap. 8). Yet, the movement was a progressive one as it did not advocate an outright policy of 'going back to the past'. It, in fact, adopted the same strategies, models and techniques as their Christian missionary opponents to further their aims, i.e. printed media, public debates, modern organizational techniques, educational institutions, Sunday schools, etc. (Obeyesekere: 1975a, De Silva & Malalgoda: 1977, 379-402).

The Westernized, propertied elite who dominated the campaign initially for a greater share of power under the British in the early

5. The growth of Sri Lanka's economy mostly as an appendage of the metropolitan economy determined the nature and composition of the native capitalist class which whose interests were complementary to those of the foreigners who invested in the country. For a detailed discussion, see Silva: 1982, chapter 3).

decades of the 20th century and later for winning independence did not have much sympathy for the nationalist cause though they were not openly hostile towards it. As one might expect, the movement found its support base largely in the lower social layers, particularly in the rural areas. The rural petty-bourgeoisie and the lower middle class, consisting of vernacular educated petty officials, school teachers, Ayurvedic physicians, etc. provided most of the activists for the temperance societies which constituted an integral part of the nationalist movement.

The westernized political elite, already clamoring for greater power, however could not ignore or by-pass the nationalist movement which had a mass appeal. Given the increasing tendency towards representative politics in the few decades preceding political independence, they were forced to rely on the temperance societies scattered in many parts of the country to mobilize popular support.⁶ But, this did not make them any more sympathetic towards the nationalist cause.

The modernized native political elite sustained their hegemony in the national political arena and eventually took over power from the British in 1948. Given the multi-ethnic, multi-religious and multi-lingual character of the population of Sri Lanka, the resultant containment of the nationalist agitation which was mostly Sinhalese-Buddhist in orientation also meant at least a temporary containment of the divisive tendencies that were already evident in the national body politic. But, at the same time, it also frustrated many whose specific grievances were left unheeded and were only to be taken up soon by a section of the elite itself, culminating in a mass political movement which not only overthrew the regime dominated by the Westernized elite, at least for the moment, but had far reaching implications for the political process ever since.

Ayurvedic physicians constituted an integral part of the popular base of the nationalist movement. This was understandable in view of the fact that they continued to be marginalized throughout colonial rule in the face of the growing significance and dominance of Western medicine, both as a profession as well as an institution. Public health campaigns launched by the state to eradicate widespread endemic diseases such as malaria and the hospitals and dispensaries that were established almost throughout the country had a considerable impact on the illness behaviour of the general population. Much higher social esteem of Western medical practitioners who were then drawn mostly from affluent, anglicized families further widened the social distance between the former and the native practitioners who were mostly ordinary rural inhabitants with a

6. In fact, it has been noted by historians that one leading native elite family which dominated the national political arena before and soon after independence had launched themselves into national politics through these societies (De Silva: 1981)

native life-style. This situation was all too conducive for the development of a feeling of social inferiority among the latter who seem to have enjoyed considerable social prestige in pre-colonial society. This is evident in the honorifics such as *veda rala* and *veda mahathtaya* used in addressing them. Such honorifics as *rala* and *mahaththaya* had normally been used to address local chiefs such as village and divisional headmen such as *rate rala* and *rate mahathaya*.

Local Ayurvedic system had probably begun to decline much earlier than the dawn of Western colonial rule. Political instability that characterized the several centuries preceding the advent of the colonial period would not have facilitated the development of a centralized medical system consisting of "centres of excellence" capable of performing such vital functions as the generation and dissemination of knowledge and the development of new techniques. While a few leading proponents of Ayurveda, based in population centres, seemed to have continued their practice in close consultation with the ancient texts, their impact would have been largely confined to a small retinue of apprentices drawn from the immediate vicinity. The bulk of the practitioners scattered in rural hamlets would not have had more than a symbolic identification with these centres. Their remoteness from the latter would have deprived them of opportunities for face-to-face interaction with a larger community of practitioners, securing information about new techniques and pharmaceuticals, if any.

Stagnation or even decline of empirical medicine, particularly in the periphery, would have contributed to the expansion of magical and ritual healing practices (cf. Hettige 1984: 48-51). One consequence of the decline seems to have been the blurring of the lines separating the empirical from the magical components of Ayurveda itself. The two branches which are quite distinct from each other in the textual context (Obeyesekere 1977) tended, in practice, to overlap to a considerable extent, particularly in frontier villages. Some writers seem to consider this overlapping as intrinsic to the native system of healing (cf. Kapferer 1977), but it is more reasonable to assume that it is a manifestation of the remoteness and parochiality of local practice. This is partly evident from the fact that those who are familiar with ancient texts pay little or no attention to ritual healing practices. The very fact that the exorcists refer to *tun dos* (and corresponding symptoms) and then attribute them to named demons in the context of their rituals⁷ indicates that they have transformed natural forces into supernatural ones with whom only they could deal by virtue of their mastery of demonology (*yaksha-bhuthaa vidya*). This is an almost inevitable tendency when there

7. As Kapferer has noted, exorcists draw clear parallels between ailments related to the three humours on the one hand and those symptoms which are attributed to three named demons. For details, see Kapferer: 1977).

are no specialists who are capable of managing or controlling the natural forces, i.e. the three humours. Decline of Ayurveda, at least in theory, provides such a setting. Those who use magical spells to increase the efficacy of their decoctions again demonstrate their remoteness from the centre, their limited acquaintance with the texts and techniques and their own lack of confidence.

As mentioned before, no steps had been taken during colonial rule to resuscitate Ayurvedic medicine, propagation of which continued to be the responsibility of its adherents, i.e. local practitioners and their patrons. In this, they were aided by several factors. Firstly, as already mentioned, Western medical practitioners were few and far between so that the ordinary villagers had no easy access to Western medicine. On the other hand, there were native practitioners in the villages who might have been familiar with at least the basic ideas of Ayurveda. Sinhalese villagers no doubt turned to them in the case of many common ailments. Secondly, though the villagers in general did not seem to have any hesitation in using Western medicine whenever and wherever possible, owing to their own familiarity with the elementary ideas of Ayurveda such as the humoral theory, they would have felt more homely with Ayurvedic treatment. And finally, the already mentioned nationalist movement no doubt aroused new hopes among the already marginalized native medical practitioners.

Diverse circumstances outlined so far enhanced the position of Western medicine in the local milieu, but, at the same time, they helped sustain native healing practices as well. So, the widespread acceptance of Western treatment that followed did not lead to a displacement of conventional sources of relief. In fact, the villagers and even many people in the towns continued to resort to more than one source. This has given rise to a complex pattern of illness behaviour. Empirically, at least six categories of behaviour can be identified. They are:

1. Resort to empirical medicine, either Western or indigenous, and remain within it for the entire duration of the illness,
2. Resort to ritual healing and remain within it for the entire duration of the illness,
3. Resort to ritual healing but subsequently shift to empirical medicine,
4. Resort to Western medicine but subsequently shift to Ayurvedic medicine,
5. Resort to Ayurvedic medicine but subsequently shift to Western medicine,
6. Resort to multiple sources of relief simultaneously.

Adoption of one or the other of the above behavioural modes is dependent on a host of situational factors such as the choices available, perceived cause and nature of illness, beliefs of individuals, families and communities, past experience, both real and perceived, attributes of the afflicted such as age, and so on. The list, however indicates how wide the range of options available and often resorted to. It is not implied here that all the listed behavioural categories are of equal significance. Nor is it possible to divide the population in terms of these categories as many people shift from one category to another depending on the situation. The complexity involved cannot be sorted out without having access to longitudinal behavioural data collected through intensive ethnographic fieldwork. But, this was beyond the scope of the present study.

As far as the present paper is concerned, significance of the above complexity lies in the fact that it has influenced public discourse on the relative significance of Western and Ayurvedic medicine in the national setting. As indicated before, the latter continued to play an important role throughout colonial period in spite of the fact that it did not enjoy state patronage. But, in the face of a dominant, Western medical establishment, native physicians became increasingly marginalized. It is these circumstances that elevated them to the level of a major partner in the nationalist struggle. But the very fact that the interests of the social groups involved lied outside the major colonial economic structures such as plantations, business and modern professions deprived them of the leadership of a dominant native capitalist class. Interests of the latter in Sri Lanka, unlike those of its counterpart in the Indian subcontinent, were complementary to the economic interests of the centre so that either side experienced no major difficulties in working together for a peaceful transition through a constitutional process. This meant that the social groups who found refuge in the nationalist movement could not have much influence on the political process leading towards independence - a process guided mainly by the colonial administration. But the process of political evolution itself which prepared the ground work for popular politics soon paved the way for the formation of a successful national-level political alliance giving expression to most of what the Sinhalese-Buddhist Nationalist movement stood for. This was the coalition led by the newly formed Sri Lanka Freedom Party (SLFP) which swept into power in the 1956 general elections.

The establishment of a government in 1956 sensitive to the demands of the nationalist movement cleared the way for state patronage in favour of Ayurvedic medicine as well. The institutions that were established to foster the latter has some correspondence with those of the Western medical establishment though the gulf between the two remains as wide as ever in terms of visibility, economic interests, social standing etc. The establishment of an Ayurvedic Research Institute, a College

of Ayurveda which was later upgraded to the level of a teaching faculty affiliated to a state university, public dispensaries, hospitals and a state corporation dealing with Ayurvedic pharmaceuticals, and the recently created Ministry of Indigenous Medicine were to largely replicate the institutional structures of the Western medical establishment.

None of the above steps, however, were prejudicial to the Western medical establishment. For instance, they did not have any adverse effect on the dominant position of the latter in terms of its social and political influence, economic interests, scope of its organizational structures such as teaching faculties, hospitals, public health campaigns, primary healthcare networks, professional and academic bodies, research institutes and public patronage. Nevertheless, the creation of national-level organizational structures dealing with Ayurvedic medicine has been instrumental in bringing into focus the interface between the two systems in recent years. Public and academic discourse that has ensued has raised many interesting issues. Some of them are: (a) what are the relative merits and demerits of the two systems?, (b) are they complementary or contradictory? and (c) can they be integrated within a single healthcare system, in terms of both teaching and practice?.

Any attempt to reasonably deal with any of the above questions is beyond the capacity of the author. What is attempted instead in the remaining pages is to focus attention on some of the sociological manifestations of the interface between the two systems with a view to pointing to their possible implications.

Interface Between Ayurvedic and Western Systems of Medicine

The creation of national-level institutional structures no doubt enhanced the position of Ayurveda in the national context at least to a limited extent. Yet, it is certain that this enhancement was achieved not at the expense of Western medicine, for the latter continued to be as dominant and influential as ever. Recent survey data indicates that most people in the country in general seek Western treatment. Though it would be unwise to read too much into superficial statistics, the latter nevertheless point to certain general patterns (see Table 1).

Table 1: Sources of Treatment Resorted to by Patients

<u>Source</u>	<u>% of Respondents</u>
Ayurveda (Govt.)	2.18
Ayurveda (Private)	12.07
Western (Govt.)	45.56
Western (Private)	34.21
Homoeopathy	0.35
Acupuncture	0.14
Other	5.49
<u>Total</u>	<u>100.00</u>

Source: Consumer Finances Survey of the Central Bank of Ceylon, Colombo, 1981/82

The statistics in the above table are based on an islandwide sample survey conducted by the Central Bank of Ceylon. The figures are computed on the basis of the answers given by the respondents in response to a question regarding the last illness episode and the type of treatment resorted by them.

Such a survey has several inherent weaknesses. Firstly, it relies heavily on subjective responses. Since we have no information on the subjective definition or definitions of illness episode, it is not possible to determine whether minor ailments which did not require the attention of a Western doctor but nevertheless, treated either with home remedies or Ayurvedic medicine, with or without involving a physician, were covered by the definition. Secondly, we do not know whether the sources of Western medicine cited also included those indigenous practitioners who dispense Western medicine. Despite these ambiguities, however, it is clear that there is overwhelming tendency among patients to seek Western medical treatment, at least for certain ailments. Moreover, over 45% of the respondents have relied on public health services for treatment.

In spite of the overwhelming dominance of the Western medical establishment, as mentioned before, many people in rural areas still have no easy access to Western practitioners. Though the number of doctors has increased over the past several decades, it still remains as low as 15 per 100,000 population (Peebles, op. cit. 46). On the other hand, it is said that there are about 10,000 indigenous medical practitioners scattered throughout the country. In other words, over 60 practitioners per 100,000 persons. Yet, little is known about these practitioners, so we do not know for sure what percentage of them are with a comprehensive training, either formal or informal. It may be that many of them are no more than simple herbalists who have inherited a rudimentary practice from their parents or elders. Furthermore, we do not know whether they also include self-appointed native practitioners or quacks. Nevertheless, there cannot be any doubt that all those who practice some form of native medicine outnumber Western practitioners. But, how many of them operate within the Ayurvedic tradition is anybody's guess.

As mentioned before, Western practitioners are mostly concentrated in urban areas and they usually have their dispensaries in urban centres and towns. On the other hand, their relatively small numbers reduce competition, allowing them to derive substantial incomes. This has reinforced their superior social position vis-a-vis most native practitioners even in their midst, let alone those having their practice in the rural backwaters.

Some of the factors that helped widen the social distance between Western and Ayurvedic practitioners were already mentioned. Recent measures taken by the state to foster indigenous medicine have not resulted in any narrowing of the gap. Nevertheless, the above measures have been instrumental in setting in motion a process of change, particularly focussed on the newly established University Faculty of Indigenous Medicine which seems to provide a qualitatively different setting for the training of native medical practitioners drawn from among young school leavers who have been exposed to the same school setting as their counterparts in the Western medical schools. While it is true that the former by and large hail from rural families with a background in indigenous medical practice, they cannot be expected to be very different from the latter in terms of their values, aspirations and attitudes. Though they are trained in a medical tradition which is very different to the Western one, their exposure to Western doctors, and through them, to basic elements of modern medical science such as physiology, anatomy and pharmacology could have a lasting influence on their behaviour. As is already evident, they do not seem to be happy to play the role of a junior partner to their Western counterparts and subsist on the "left-overs". Yet, they are not in a position to alter the patterns of illness behaviour that have surfaced in the recent years.

For most people who have access to both types of medicine, they are not so much competitive systems as complementary ones; many people tend to combine the two in numerous ways depending on the illness, response of the medicaments prescribed, etc. On the other hand, there are not many people today who rely entirely on indigenous medicine. But, there are many who depend entirely on Western medicine.⁸

Once set against the system of Western medicine and modern experimental science, the indigenous system is bound to face new challenges, not only at the level of practice but also at many other points. The almost inevitable challenge that the Indian indigenous practitioners were to face, clearly stated by Nehru in the quotation cited below, is equally relevant for Sri Lanka. Nationalist leaders in India who were quick to take steps to foster indigenous medicine there even before independence were equally committed and faithful to modern medical science. This meant that they did not extend unqualified support for indigenous

8. The tendency among many villagers to constantly combine different sources of relief, i.e. empirical with magical, reinforces belief in different systems as they find it difficult to disentangle diverse cause and effect relationships, both real and perceived. While a patient is in the hospital receiving treatment, family members may make a vow at the local temple or devale, or get an exorcist to perform a minor ritual in his or her favour, etc. The eventual recovery of the patient may be attributed to the efficacy of not only hospital treatment but also various other acts performed. Should the patient die in hospital, it may be interpreted as a result of a maraka (a fatal moment or period) which the horoscope reader foretold.

medicine and, in fact expected the latter to live upto the standards set by modern Western science, In other words, what is involved here is an attempt to transform indigenous medicine into modern scientific idiom.

“...We cannot expect to improve our standards unless we take full advantage of science and modern scientific methods. There is no reason why we should not bring about an alliance of an old experience and knowledge as exemplified in the Ayurvedic and Yunani systems with the new knowledge that modern science has given us. It is necessary, however, that every approach to this problem should be made on the basis of the scientific method, and persons who are Ayurvedic and Yunani physicians would have also a full knowledge of modern methods. This means there should be basic training in scientific methods for all, including those who wish to practice Ayurvedic or Yunani systems. Having got that basic training, a person may practice either of these systems or homoeopathy. The question is thus not of a conflict between various systems but of sound education in knowledge as it is today, and then the freedom to apply it according to any system. It is the scientific approach that is important.” (As quoted in Keswani: 1969)

It is not intended here to speculate on how reasonable or logical the challenge itself is or on how successful the native systems be in meeting the challenge. What should be noted, however, is that the challenge posed is a real one and is going to be mounted on several fronts at different levels, as it seems to have happened in India and elsewhere. Moreover, it should also be noted that, since the ‘rules of the game’ are drawn from modern medical science, the latter has in effect been elevated to the level of the ideal.

Yet, the test itself is going to be a long-drawn-out one, so it would be many years before one would know the final outcome. Furthermore, some practitioners may remain outside the test arena, thereby avoiding or ignoring the challenge or may carry on regardless so long as they have a reasonable clientele. The scope and the outcome of public discourse, however will have a direct bearing on the clientele, at least in the long run, thereby making it either easy or difficult to remain aloof.

As mentioned before, the nationalist demand for the restoration of Ayurveda was met by establishing organizational structures largely modelled on those of the Western system. This led to the ‘opening up’ of the system resulting in a substantial decline in its autonomy. Its pharmaceuticals are now being tested in modern laboratories to verify their supposed effects. Its treatment procedures are scrutinized to determine their rate of success. Students in the Faculty of Indigenous medicine are taught elements of Western medical science curriculum but not vice versa, and so on. The process of incorporation is a slow one and will continue for a long time to come.

The process, however is not simply a one-sided affair. For instance, the recent attempts to foster indigenous medicine through the establishment of national-level institutions have also been instrumental in reviving certain age-old customs and habits. The programme that was launched under the sponsorship of the newly established government Ministry of Indigenous Medicine to popularize herbal drinks, particularly in the urban areas is a clear case in point. While a network of stalls selling such drinks were established, the programme was given visibility and publicity through media campaigns. It should be noted here that, before the spread of the tea drinking habit in the country subsequent to the establishment of tea plantations in the second half of the 19th century, various herbal drinks had been very popular among the local population. Subsequently, this habit faded into the background and herbal drinks survived mostly as a source of relief for minor ailments.

Another custom that was revived was the traditional oil anointing ritual, connected with the Sinhalese new year in the month of April. It has been customary for the Sinhalese to begin the new year with a set of household rituals including oil anointing, usually performed by an elder or the head of the household on the prescribed auspicious time. In the recent years, it has been turned into a public ceremony, held at the Ayurvedic Research Institute, situated to the south of Colombo, with the participation of the Minister in charge of indigenous medicine and higher officials of the relevant institutions.

Whether the above habits and customs were associated with Ayurvedic system or whether they existed independent of the latter in the past is not relevant for the current practice. What is significant is the attempt that has been made to demonstrate the social and cultural relevance of Ayurveda. Moreover, there have also been attempt to point out that indigenous medicine has the potential to play an important role, side by side with Western medicine, in national-level programmes such as the anti-malaria campaign. This was amply demonstrated when steps were taken by the indigenous medical establishment to dispatch Ayurvedic physicians with traditional drugs to the north-western region of the country where there was an outbreak of Japanese encephelitis in 1987. The treatment campaign was spearheaded by the Western medical establishment which was later joined by some Ayurvedic physicians.

Meanwhile, the practitioners of Ayurvedic medicine are adapting to the patterns of illness behaviour prevalent in society. It is also noteworthy that the community of indigenous practitioners has been further differentiated, largely under the influence of the measures taken by the state. At the risk of a certain degree of simplification, it is possible to identify three main categories of practitioners today. They are:

- (a) Traditional, leading proponents of Ayurveda and their retinue
- (b) Vaguely Ayurvedic herbalists
- (c) Modern adapted Ayurvedic practitioners.

The first category consists of practitioners who remain very much within the mainstream of Ayurveda. Many of them are resident in urban areas or densely populated area. Virtually everyone of them possess copies of ancient texts, or at least conversant with them. They are often literate in Sanskrit and, having gone to urban schools, may even possess a good knowledge of English. Almost all of them have a retinue around them, the latter having had their apprenticeship under these leading practitioners who are usually called *vedaduru*, in recognition of their teaching function. Because of their fame, they often attract a large clientele, from a larger area. Among their clients are also found affluent people, often drawn from elite circles. They usually have a lucrative practice and produce most of the pharmaceuticals themselves employing several full-time resident workers.

These circumstances make them feel confident and contented. They usually have no sense of inferiority vis-a-vis their Western counterparts because they feel that they are very much at the top, at least in their own field. They are not ashamed of their traditional identity: they, in fact, are proud of it and tend to consider themselves to be the guardians of the tradition. Many of them are as affluent, influential and prestigious as their Western counterparts. Ayurvedic paradigm, at least in the past, has been articulated and preserved largely by them. At the same time, they are not altogether ignorant of the elements of Western medical science.

Practitioners belonging to the second category are scattered in rural peasant hamlets. They usually have had no rigorous apprenticeship under a leading physician. Their familiarity with the tradition and indigenous practice is often the result of a family tradition or aquired through an informal association with a native practitioner in the locality, often as an aid to the latter. Their clientele does not usually extend beyond the immediate locality and, therefore, consists of poor villagers. This often makes it difficult for them to subsist entirely on what they derive from their practice and they themselves are not more than humble villagers. Their links with the centres are often not more than symbolic. They neither produce nor maintain stocks of medicinal preparations in substantial quantities. There is, therefore, no practice of dispensing preparations to patients, except certain medicinal oils or balms which they themselves prepare. Nowadays, even humble villagers would turn to them only for minor ailments. In fact, they themselves direct people with more than a minor complain to a more notable practitioner in the vicinity, either Western or indigenous, or to the nearest public hospital.

The last category consists mostly of relatively younger practitioners who have had a formal training at the newly established Indigenous Medical College. They are a distinct sociological category, radically different from the first two. As mentioned before, apart from their own subjects of Ayurveda, they are also exposed to a dose of Western medical science. The positive effects of this exposure apart, it no doubt generates an alienating influence resulting in a significant role conflict in them.

Many of them are youngsters who sat the same national examination as the other university entrants, including those admitted to the Western medical colleges, but they usually do not have adequate qualifications to seek admission to the latter. But, this does not mean that they cease to be aspirants to modern life-styles in terms of dress, consumption patterns, social roles identity and status.

Normal practice among Sinhalese villagers is to distinguish between native practitioners and Western physicians using radically different terminologies. While *veda mahattaya* is used to refer to the former, *dostara mahattaya* is used to identify the latter. In the past, there was no confusion regarding this distinction as the two practitioners represented two radically different images.

A Western doctor was Western not only in terms of his training, diagnostic and surgical paraphernalia used and medicines prescribed but also in terms of his life-style and appearance. He wore a Western dress, usually spoke English among themselves, always carried stethoscope, practiced in a modern clinic which could be clearly noticed from a distance by the distinct signboard displaced outside and the general appearance, prescribed modern drugs which could be obtained only from a modern pharmacy in the town, displayed little regard for traditional food habits prevalent in the villages and so on. Relationship between the physician and the patient was usually characterized by impersonality and social distance and the former often handled no money himself. In his clinic, he was assisted by a uniformed nurse and/or a dispenser who normally accepted fees for consultation and medicine. In other words, he was not very different from his counterparts in the Western countries.

By contrast, an Ayurvedic physician was very much traditional in his dress, general appearance and manners. He wore a traditional dress, spoke the local dialect and usually carried no diagnostic and surgical instruments. His clinic was usually a section or a room in his own house, where he kept some medicines and old medical texts, usually in the form of ola leaf manuscripts. He would explain to the patient or the person accompanying him or her, the nature of the ailment, its possible causes, and the remedies prescribed, often accompanied by dietary prescriptions which, he would stress, might have a direct bearing

on the efficacy of the medicine prescribed and eventual recovery. The prescription itself, written in stylized Sinhala, was often a formula for the preparation of a decoction involving many herbal ingredients which the patient either had to gather from the locality or purchase from a stall selling such ingredients, or both. Physician usually accepted a fee himself, often disguised inside a bundle of betel-leaves.

Even though all the Ayurvedic practitioners, particularly those who practice in the urban areas, do not fit the above description today, the basic distinction between the two remains broadly to date. Moreover, there are many native practitioners who fit into the traditional stereo-type. Yet, with the rise of young, modernized Ayurvedic practitioners, an anomalous situation has been created.

Unlike the General Practitioners, trained in the Western tradition, who have completed their medical education in the English medium, young Ayurvedic practitioners are mostly vernacular educated. They both wear some form of Western dress, Western doctors usually wearing a tie as well, as if to dispell any doubts about their "Westernness". The external appearance of private "dispensaries and surgeries", as they are called, of both groups are virtually identical today. Their internal structures also resemble each other to a considerable extent. Diagnostic instruments such as stethoscopes, blood-pressure monitors, etc. which could be seen only in Western medical clinics in the past are now commonly used in dispensaries run by young Ayurvedic practitioners. Some of them prescribe Western drugs, along with their own. Many of them appear so much like their Western counterparts that it would not be surprising if some ignorant villagers confused them for Western medical practitioners.

The blurring of the boundaries separating Western practitioners from some of their indigenous counterparts is highly significant in view of today's widespread tendency to seek Western treatment. In this regard, it should also be noted that, unlike their Western counterparts who tend to concentrate in urban areas, young Ayurvedic practitioners, after training, tend to return to their village areas where there is not yet much competition from Western doctors. Many rural patients who would otherwise travel to towns seeking Western treatment may now be attracted by these adapted Ayurvedic practitioners some of whom have no hesitation in dispensing Western drugs. They also have an added advantage of being able to speak in an idiom which is easily understood by the ordinary villagers. Many patients, however, find it awkward to address them as *veda mahatmaya*, even when they know that they are not Western doctors.

On the other hand, some patients who look for a real Ayurvedic practitioner might be reluctant to approach one of these modernized

practitioners as they do not appear to be the real proponents of Ayurveda, in spite of the fact that they, in fact, have received a comprehensive training in the field. Such patients are likely to turn to a traditional-style indigenous practitioner, usually one who is renowned in the area.

Summary and Conclusion:

Several issues were raised at the outset of the paper. An attempt has already been made to deal with them in some detail. As was seen, introduction of Western medicine to Sri Lanka and its eventual expansion there resulted in the marginalization of the indigenous systems, leading to some form of a devaluation of the latter. The rise of Sinhalese-Buddhist nationalism in the later half of the 19th century was responsible for arousing hopes among Ayurvedic practitioners, but the subsequent dominance of the Westernized, propertied elite was responsible for the subordination of the interests of the groups encapsulated within the nationalist movement to those of the colonial elite. It was only after independence that the marginalized sections of the Sinhalese Buddhist population including Ayurvedic physicians could assert themselves through popular politics and achieve some of their aims. Subsequent steps taken by the state to foster Ayurvedic medicine set in motion a process of change but did not significantly alter the state of affairs that had already been established. Neither the dominance and established social superiority of the Western medical establishment nor the main patterns of illness behaviour in the population were drastically affected by the changes.

One aspect of the above process of change was the differentiation that has taken place within the community of indigenous practitioners. Perhaps the most significant dimension of this differentiation was the rise of a category of modernized or adapted Ayurvedic practitioners who in their own way, have contributed to the blurring of the lines separating indigenous and Western medicine at the grass-roots-level. Given the present arrangements for training indigenous practitioners, largely focussed on the modernized setting of a University Faculty and the social backgrounds of the new recruits, this category is bound to grow in both number and significance in the years to come. Given their increasing commitment to a modern life-style, they are certain to feel the growing competition from their Western counterparts. On the other hand, their own dynamism may help them resist such competition and carve out a share of the market which has been expanding in recent years in keeping with the deterioration of country's public health network. This would not be to the liking of young Western practitioners who are eager to quit less remunerative public service at the end of the period of their compulsory service in order to embark on a more

lucrative private practice, preferably in a suburban area outside the already congested urban centres. Unlike their indigenous counterparts, the young Western doctors who emulate their already established seniors with an elitist life-style have very high aspirations. So, all the signs are that the stage is going to be set soon for the enactment of yet another drama within the framework of popular politics, with the participation of many actors representing diverse interests and ideological groups associated with the two medical establishments. The outcome of the drama will have a direct effect on the future relationship between the two systems, particularly in the form of a determination of the relative position and role of each of the two systems in the future healthcare system of Sri Lanka.

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