The Body Politic and the Nationalist Cure: Ayurvedic Revivalism Against Colonial Hegemony in Punjab, 1858–1910

Ateeq-ur-Rehman Sajid*

Abstract

This research paper investigates the profound crisis and subsequent revival of the Ayurvedic medical system in the Punjab region during the crucial period of high British imperialism, spanning 1858 to 1910. The advent of the British Raj brought with it the imposition of Western biomedicine, a system that, unlike its traditional counterparts, enjoyed immediate and overwhelming state patronage. This state support was systematically deployed to marginalize and suppress indigenous healing traditions, particularly Ayurveda, through restrictive policies and the establishment of government-funded medical institutions. The research maps the initial structural threats posed by colonial legislation, such as the debate surrounding medical registration, which effectively sought to delegitimize Vaids and Hakims. More importantly, it examines the spirited and organized resistance mounted by the practitioners of indigenous medicine. This resistance transformed into a major cultural and political movement, marked by the mobilization of Vaids, the formation of nationalist conferences like the All-India Ayurvedic Conference, and the strategic leveraging of modern print culture. The essay demonstrates that the revival of Ayurveda was not merely a reaction to external threat but a conscious, nationalist project. It became a powerful ideological tool, aligning the restoration of traditional medical knowledge with the broader political demand for *swaraj*, thus transforming healthcare from a matter of healing into a central pillar of anti-colonial identity in Punjab.

Keywords: Ayurveda, Colonialism, Punjab, Revivalism, Print Culture

* Independent Scholar. Email: sheikhateeq709@gmail.com
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The latter half of the nineteenth century in British India marked a period of intense cultural collision, where indigenous traditions struggled to retain relevance and legitimacy against the imposing structure of the colonial state. Nowhere was this contest more acute than in the field of medicine, which transcended simple matters of health and became deeply intertwined with political power, cultural pride, and ideological control. The arrival of Western medicine, or biomedicine, was not a gentle introduction but rather an aggressive assertion of scientific and cultural supremacy, armed with the formidable backing of the British Raj (Arnold 1993). This study examines the specific confrontation that unfolded in Punjab, a region brought under formal British control in 1849, whose subsequent policies between 1858 and 1910 offer a distilled case study of the colonial-medical nexus.

The core argument of this paper posits that the western medical system, underpinned by state patronage, actively sought to dismantle and suppress the established Ayurvedic and Unani traditions through the implementation of strict state policies and the direct exertion of institutional influence. The authorities employed a strategy of marginalization, designating their own system as 'scientific' and 'rational,' while relegating indigenous practices to the realm of the 'unqualified' or the 'quack' (Harrison 2001). This dynamic created an existential threat for the centuries-old practice of Ayurveda, which had previously flourished under various indigenous and Muslim rulers. However, this suppression catalyzed a profound counter-movement from the Vaids (Ayurvedic practitioners).

This paper illuminates the dual nature of the Vaids' response: the resistance to specific colonial medical policies and the broader mobilization efforts rooted in nationalist sentiment. Through organized conferences, sophisticated print campaigns, and strategic engagement with the populace, Vaids and Hakims began a powerful movement of revivalism. Their efforts were consciously aimed at building a status for Ayurvedic medicine that mirrored the emerging professionalization of Western practice, while simultaneously embedding it within the anti-colonial political ideology of *swadeshi* and *swaraj*. By focusing on Punjab, this analysis provides a localized, detailed account of how the Indian medical tradition survived, adapted, and ultimately utilized the challenge of imperialism to reinvent itself as a vital symbol of national renewal during a critical juncture in South Asian history.

The academic discourse on the history of medicine in colonial India largely revolves around two distinct but intersecting streams: the nature of colonial medical encounter and the subsequent indigenous responses. Scholars like Deepak Kumar have detailed the initial period of unequal contention, arguing that the British used institutional power to popularize Western medical knowledge while simultaneously running campaigns that labeled indigenous practitioners as quacks (Kumar 1997). This era, spanning the early to mid-nineteenth century, initially saw a period of syncretism, which soon gave way to the colonial agenda of marginalization, creating the very conditions for the later revivalist push.

A second, highly influential stream of scholarship identifies the revival of local medicine as intrinsically linked to the growing Indian nationalist project. Poonam

Bala and Uma Ganesan argue that the promoters of Ayurveda intentionally launched a movement that became a key cultural icon of the Indian National Movement (Bala 1990; Ganesan 2010). This view is reinforced by B. D. Metcaff, who demonstrated how the mobilization of key figures like Hakim Ajmal Khan strategically aligned traditional medicine with the demand for self-rule (*swaraj*), effectively transforming a professional dispute into a political struggle (Metcaff 1995). These studies emphasize that the return to indigenous medicine was often framed as a rejection of imperial hegemony, positioning local healing systems as symbols of national, scientific, and cultural progress (Mahatma and Supe 2016).

Crucially, some scholars have refined this nationalistic lens by focusing on the mechanisms of revival, particularly institutionalization and print culture. Kavita Sivaramakrishnan's work on Colonial Punjab highlights how print publicity and mobilization efforts by practitioners were vital in recasting indigenous medical knowledge into the modern public domain (Sivaramakrishnan 2006). Mark Harrison complements this by noting how the ascendancy of pharmaceutical industries and advertising paved the way for the commodification of local medicines, forcing Vaids and Hakims to adopt new forms of media to advertise and legitimize their practices (Harrison 2015). Madhuri Sharma further emphasizes the institutional aspect, contending that proponents of Ayurveda successfully re-established rival institutions, creating an infrastructure that allowed Ayurveda to compete despite internal disagreements and external bureaucratic hostility (Sharma 2012). This study builds upon these foundations by merging the political-nationalist argument with the structural analysis of policy and the cultural impact of print media, focusing the entire scope on the unique and understudied context of Punjab between 1858 and 1910.

The methodological approach adopted here is primarily historical and analytical, rooted in the framework of cultural history, which views medicine as a contested cultural space rather than a purely scientific domain. Following the established approach of scholars like Kavita Sivaramakrishnan, the research pieces together a narrative history of the indigenous healthcare system by analyzing the interaction between official colonial records and local responses (Cheema 2013). This involves scrutinizing government proceedings, reports on medical education, and legislative debates (such as the contentious Medical Registration Act) against the writings, manifestos, and public discourses found in vernacular sources, conference proceedings, and the biographies of leading Vaids and Hakims.

Furthermore, this analysis employs Louis Althusser's theory of Ideological State Apparatuses (ISAs) to provide a theoretical framework for understanding the mechanisms of colonial control and indigenous resistance. Althusser suggests that the dominant ideology is reproduced not just through repressive means (Repressive State Apparatuses like the police and military), but through seemingly benign institutions (ISAs) such as the educational and family systems (Althusser 1971). The colonial medical establishment, including hospitals, medical colleges, and the Indian Medical Service, can be understood as an ISA. It was tasked with interpellating the populace—and even indigenous practitioners—into recognizing the

superiority of Western science and, by extension, the British colonial project.

This theoretical lens allows the study to move beyond a simple narrative of good-versus-evil and analyze the complex ways in which colonial policy was an ideological project designed to shape Indian subjectivity, defining what constituted legitimate knowledge and practice. The indigenous response, therefore, can be viewed as an attempt to construct a counter-hegemony—a competing ideology—by reclaiming the status of Ayurveda and aligning it with an emergent national consciousness. The primary sources utilized include government proceedings, reports like those by Muhammad Usman, and accounts from vernacular publications like *Abhyudaya* (Abhyudaya 1909), while secondary sources are drawn exclusively from scholarly and peer-reviewed literature to maintain academic rigor and to ensure the humanistic, analytical tone is consistently applied.

The Ancient Foundations and Pre-Colonial Flourishing of Ayurveda

The genesis of Indian medicine predates recorded history, with archaeological evidence from the Indus Valley Civilization hinting at sophisticated concepts of public sanitation and medical awareness (Sigerist 1961). Findings at Harappa and Mohenjo-Daro, particularly the presence of comprehensive drainage systems and public baths, suggest an early recognition of the link between hygiene and communal well-being. This was a form of preventative health on a societal scale, a concept far ahead of its time and a powerful demonstration of ancient Indian technological and scientific acumen. Even in this earliest stage, the civilization displayed a remarkable capacity for large-scale organization dedicated to the maintenance of health.

The true cornerstone of the Indian therapeutic tradition, however, is Ayurveda, whose origins are often traced to the sacred knowledge contained within the Vedas. While the later Vedic period, particularly the *Atharvaveda*, contains numerous incantations and magical remedies, it also documents an increasingly sophisticated pharmacopoeia and an emerging rational approach to disease (Boss, Sen, and Subbarayappa 1971). The transition from purely theurgic explanations of illness—appeasing an angry deity—to logical and scientific components of diagnosis and treatment marks a crucial evolution in Indian intellectual history. This development, as seen in the later Vedic Samhitas, reflects an early awareness of anatomical, physiological, and pathological concepts that were foundational to future medical schools.

The classical period, roughly spanning 300 B.C. to 1000 A.D., witnessed the codification of this knowledge into the great foundational texts: the *Charaka Samhita* and the *Sushruta Samhita*. These texts are not mere collections of remedies; they represent fully developed systems of pathology, therapeutics, and surgical knowledge. *Charaka Samhita*, focusing heavily on internal medicine, provided the intellectual infrastructure for the physician, emphasizing the crucial balance within the body for maintaining health. It defined health as a harmony of the body, mind, and soul, establishing the holistic nature that would become Ayurveda's enduring hallmark.

The *Sushruta Samhita*, in contrast, stands as a seminal work in surgical knowledge, detailing hundreds of instruments and procedures that were startlingly advanced for the ancient world. It is renowned for its

specific, highly detailed descriptions of plastic surgery, including rhinoplasty, which demonstrate an extraordinary mastery of human anatomy. The comprehensive nature of these works indicates that the medical profession was highly specialized and respected, attracting students from across the civilized world, including Rome, Greece, and Persia (Kutumbiah 1962). This reputation solidified India's status as a global hub of medical learning centuries before the European medieval period.

The intellectual framework of Ayurveda rests upon the dual theories of *Tridhatu* (elements) and *Tridoshas* (functional energies or humors). This conceptualization views the human body not as a static machine but as a dynamic, interactive environment composed of five fundamental *Panchamahabhutas*—Earth, Water, Fire, Air, and Akas (Space) (Frawley and Ranade 2004). All matter, including the human body, is constituted by these elements, which combine to form the building blocks of the organism, the *Anus* or cells.

From these elemental interactions, the three functional forces, the *Doshas*, emerge: *Vata* (motion), *Pitta* (metabolism/heat), and *Kapha* (structure/lubrication). *Vata* governs all kinetic activities of the body and mind, from breathing and nerve impulses to muscle movement, and is primarily associated with the elements of air and space. *Pitta*, manifesting as fire, is responsible for all thermogenic processes, digestion, transformation of food into *rasa* (cellular tissue), and intelligence. *Kapha*, associated with water and earth, provides cohesion, stability, and mass, and is rooted in all structural tissues and fluids (Vyas and Kothari 1998).

Health (*Swasthya*) is defined as the state where these three *Doshas* operate in harmonious, metabolic equilibrium (*homoeostasis*). Disease, conversely, is the result of functional dysfunction or imbalance in one, two (*Dwandwan*), or all three (*Sanni Patham*) of these forces (Raman 1994). This theoretical approach highlights Ayurveda's internalistic focus: disease is often viewed as a result of internal malfunctioning, emphasizing the individual patient's *Prakriti* (temperament or constitution) as the priority in diagnosis, rather than the external pathogen.

The philosophical implication of this system is its inherent holism, as the ultimate aim of Ayurvedic practice is not merely the elimination of symptoms but the restoration of the metabolic equilibrium of the entire psychosomatic entity. This approach stood in stark contrast to the later, increasingly reductionist focus of Western medicine, which isolated and targeted external pathogens (Frawley and Ranade 2004). Consequently, the Ayurvedic system developed an unparalleled expertise in drug formulation, utilizing a vast materia medica derived from plants, minerals, and animal products, whose toxicity and therapeutic benefits were meticulously cataloged.

With the advent of Muslim rule in India, particularly during the Mughal era (1526–1707), a new, but highly compatible, system of healing arrived: the Greco-Arab or Unani system of medicine. Unani, founded upon Galenic and Hippocratic medical notions, had developed significantly in Arabia and Persia, absorbing advanced practices from China and India along its trajectory (Siddiqui 1981). Its introduction did not lead to the expected clash but instead fostered a remarkable period of synthesis and peaceful coexistence with Ayurveda.

The integration was facilitated by fundamental commonalities, most notably

the central role of humoral theory in both systems. Both Ayurveda's *Tridoshas* and Unani's four humors (*dam, balgham, safra*, and *sauda*) shared a structural and diagnostic philosophy rooted in balancing bodily fluids and energies. This shared intellectual ground allowed physicians from both traditions, Vaids and Hakims, to collaborate, compile, and exchange knowledge freely (Leslie 1998). This spirit of syncretism was actively encouraged and sponsored by the ruling elite.

The Mughal emperors provided substantial state patronage, known as *aquaf*, to both Unani hospitals and, importantly, to Vaids. Records indicate that Mughal nobles, the *mansabdars*, employed and sponsored large numbers of Vaids alongside Hakims (Habib 1963). This official, institutional support ensured the preservation of Ayurvedic knowledge and its continuous development through compilation and synthesis. Physicians like Bahwa Khan and Hakim Yoosufi actively worked to create new medical systems that blended Arabian, Persian, and Ayurvedic elements, demonstrating that indigenous practitioners possessed the skill and motivation to assimilate external information without sacrificing their core principles (Basham 1998).

The result was a dynamic, pluralistic medical landscape where both systems flourished side-by-side, benefiting from royal sponsorship and scholarly cross-pollination. This pre-colonial context is critical, as it established a powerful precedent: indigenous medicine was not a marginal practice but a prestigious, state-supported, and intellectually adaptive tradition. The subsequent decline under British rule was, therefore, not due to its inherent deficiencies or obsolescence, but a direct consequence of the withdrawal of this vital state patronage and the calculated imposition of a competing system. The memory of this flourishing past would later become the ideological engine for the revivalist movements in the late nineteenth century.

Colonial Policy and the Structural Threat to Ayurvedic Medicine (1858–1910)

The formal establishment of the British Raj in 1858 marked a decisive shift from a pluralistic, state-supported medical culture to one dominated by the ideology of Western medical superiority. The colonial administration, guided by a Victorian imperial outlook, viewed Western biomedicine as a key tool for social control and the transmission of supposedly superior European rationality (Arnold 1993). This intellectual framework was heavily influenced by a process Mark Harrison termed 'Orientalism' in the medical sphere, where European practitioners began to dismiss Indian medical traditions as 'irrational,' 'unprincipled,' and rooted in superstition, thereby justifying the political and institutional subordination of Vaids and Hakims (Harrison 2001).

One of the earliest, and most symbolic, acts of suppression occurred in 1835 when the colonial government abolished the Native Institution, which had been designed to teach both Western and indigenous medicine in the vernacular language. This policy clearly signaled a rejection of medical syncretism and a commitment to institutionalizing an exclusively Western curriculum. By the 1860s, the official policy was cemented: government-funded programmes for public health and medical care were to exclusively employ allopathic doctors, effectively cutting off state

employment, infrastructure, and financial resources from indigenous practitioners.

This institutional monopoly was enforced across the Punjab region, where the state sought to utilize Western medicine not only for its European officers and soldiers but also as a means of projecting authority onto the colonized body. The Indian Medical Service (IMS) became the central pillar of this hegemony, evolving into a rigid hierarchy that ensured the absolute domination of British-trained practitioners (Kumar 2001). Hospitals and medical schools, such as the Lahore Medical School, were established as Ideological State Apparatuses (ISAs), designed to reproduce the ideology of scientific Western dominance and to train a subordinate class of native allopathic assistants.

Despite the official policy of exclusion, the sheer lack of qualified allopathic manpower forced the colonial administration to consider limited, temporary compromises, particularly in the vast, rural expanses of Punjab. In the 1860s and 1870s, facing the logistical impossibility of providing widespread Western care, officials momentarily experimented with incorporating local practitioners. A notable example was T. W. Mercer, the Commissioner of Sialkot, who in 1867 proposed employing native Hakims in new clinics after providing them with minimal training in allopathic medicine.

The ‘Mercer experiment’ was initially successful in bridging the gap between state provision and rural demand, but it was vehemently opposed by the Western medical community. British doctors and medical bureaucrats rejected the plan, labeling it a “random sampling of Western medicine with little regard for norms of training or credentials” (Hume 1977). Crucially, the opposition was ideological: the aim, as critics noted, was not to revitalize Unani or Ayurveda, but to co-opt and ultimately undermine the indigenous systems. This brief, aborted attempt at functional cooperation demonstrates the fundamental incompatibility of the colonial project with genuine medical pluralism.

The official stance was solidified by the increasing confidence derived from scientific advancements in Europe, particularly in pathology and bacteriology. As the late nineteenth century advanced, the divide between Western medicine and traditional practices widened rapidly. Western practitioners used the germ theory, which focused on etiology and the identification of external pathogens, as a crucial cleaving point (Sivaramakrishnan 2006). They positioned this as the ultimate scientific distinction, contrasting it with the indigenous focus on *nidana* (treatment) and the balance of internal humors. This was less a substantive debate and more a rhetorical strategy to assert scientific hegemony.

The greatest institutional threat to the existence and livelihood of Vaids and Hakims emerged in the 1880s with the colonial government's efforts to enact a Medical Registration Act. Inspired by similar legislation in Britain, the proposed Act sought to create a formal, legal distinction between 'qualified' and 'unqualified' medical practitioners. Qualification was strictly defined as possessing a medical degree from a European or an officially recognized Indian university that taught the Western curriculum.

The implications for practitioners of Ayurveda and Unani Tibb were catastrophic. Exclusion from the register meant the loss of legal authority to perform basic civic functions, such as issuing death certificates, providing legally valid testimony in court, or

accessing public funds and facilities (Quaiser 2001). The colonial administration was not merely regulating medical standards; it was attempting to confer legal and moral authority—the power to determine life, death, and guilt—exclusively upon the Doctor, the Western-trained physician.

The Vaids and Hakims recognized this Act as a direct assault on their professional legitimacy and a calculated measure to drive them out of respectable practice. They quickly mobilized to protest the legislation, recognizing that the government's professional standard was less a measure of objective medical superiority and more a reflection of institutionalized state sponsorship. The debate surrounding registration became the immediate, central battleground in the struggle for medical sovereignty in Punjab and across India.

Applying Althusser's framework, the colonial medical project in Punjab can be seen as a sophisticated Ideological State Apparatus (ISA), working in tandem with the Repressive State Apparatus (RSA). While the RSA (police, military) maintained order through force, the medical ISA aimed to maintain ideological consent by defining reality and knowledge. Hospitals like Mayo Hospital in Lahore, and the medical colleges, functioned as temples of Western science, teaching subjects like anatomy and surgery that had been intentionally suppressed in traditional Indian education due to religious sensitivities.

The key function of this ISA was 'interpellation,' the process by which individuals are hailed or recognized as subjects within a given ideology. By defining the Western Doctor as the ‘qualified’ professional, the state interpellated the public into recognizing the legitimacy of Western science and, implicitly, the illegitimacy of their own medical traditions. This was a form of cultural violence, attempting to change the very way Indians perceived health, disease, and the body. The goal was to produce subjects who were ideologically conditioned to believe in the superiority of the colonizer’s scientific model (Althusser 1971).

The colonial medical policies, such as the exclusion of non-allopathic systems from official educational and employment streams, systematically reinforced this ideological split. Even well-intentioned acts, like the use of allopathic doctors in vaccination campaigns, served to foreground the dominance of the Western system. This systemic withdrawal of patronage and the simultaneous elevation of a rival system created the deep cultural and professional crisis that the Vaids were forced to confront, compelling them to articulate a counter-ideology of resistance and renewal.

The Revivalist Mobilization, Nationalist Politics, and Print Culture (1890s–1910)

The final two decades of the nineteenth century witnessed the transition of indigenous medical practices from a state of defensive retreat to one of aggressive, organized revivalism. This resurgence coincided with the explosion of political nationalism following the founding of the Indian National Congress in 1885 and the increasing momentum of Hindu and Muslim revivalist movements (Sarkar 2001). The practitioners of Ayurveda strategically adopted the prevailing language of nationalism, framing the restoration of their medical system as an essential cultural prerequisite for achieving political self-rule (*swaraj*).

The concept of “revival” hinged on the ideological belief in a past golden era of

Ayurvedic scientific splendor, followed by centuries of decline, which was decisively exacerbated by colonial rule. By claiming that a universal science had originated in ancient India, nationalists sought to reclaim a narrative of indigenous scientific genius that preceded and surpassed Western achievements (Prakash 1999). This intellectual maneuver transformed the professional defense of Vaids into a potent, emotional statement about national pride and the inherent value of Indian civilization.

The growing popularity of the *Swadeshi* movement, which advocated for the use of home-grown goods and institutions, provided the perfect political vehicle for medical revivalism. Traditional medicine was cast as the quintessential *swadeshi* product: healing rooted in local climate, utilizing local herbs, and requiring no expensive foreign imports or allegiance to a foreign power. Nationalist leaders actively discouraged the public from visiting Western hospitals, urging them instead to support traditional Vaids and Hakims. Medicine was no longer just a method of cure; it became a declaration of economic and cultural independence, fusing the concepts of *swadeshi* and *swaraj* directly onto the body politic.

The formalization of the revivalist movement was driven by the collaborative and modernizing efforts of key figures, most notably Hakim Ajmal Khan (Unani) and Vaidya P. S. Varier (Ayurveda), though they operated in geographically distant centers. Ajmal Khan, from Delhi, was instrumental in the institutionalization of Unani, establishing the Madaisah Tibbia and launching the medical journal *Mujalla-i-Tibbia* in 1902 (Metcaff 1995). His approach was one of measured modernization: he was open to Western techniques and scientific advancements, provided they could be integrated into the framework of Unani Tibb without sacrificing its core principles.

Similarly, in the south, Vaidya P. S. Varier established the Arya Vaidya Samajam and the Arya Vaidyashala, promoting both the institutional training of practitioners and the commercial manufacturing of standardized Ayurvedic medication (Panikkar 1992). Both leaders shared a common vision: the systematic, modernizing reform of their traditional systems to make them competitive in the new colonial landscape. Their work involved compiling and translating classical texts, standardizing curricula, and embracing modern organizational structures to disseminate what they termed “ancient knowledge in a new light” (Cunningham 1997).

Crucially, this leadership recognized that simple continuity was insufficient. They understood that the authority of Western medicine derived from its institutional structure and professional uniformity. In response, they worked to create a professional paradigm for indigenous medicine, aiming for parity in education, pharmaceutical production, and public relations. Their efforts moved beyond mere preservation, representing a deliberate act of professional reinvention tailored to the ideological and market conditions of the colonial era.

The true engine of the revival was the growing organized mobility of the practitioners themselves, manifested through large-scale, pan-Indian conferences. In 1907, Shriyut Pandit Shankardaji Shastri Pade of Allahabad organized the Akhil Bharatvarshiya Ayurved Mahasammelan (ABAM), or the All-India Ayurvedic Congress. This organization was explicitly founded as a professional association with clear political goals, transcending regional and linguistic

boundaries to create a collective identity for Vaids across the subcontinent.

The Memorandum of Association for the ABAM made its mission unequivocally political and professional. Its primary objective was to "develop a form of Ayurvedic polity" and "secure an effective hand in the control of the State Medical Department" (Pamphlet from AIAC meeting). The Vaids sought not just recognition, but political leverage, demanding that the government grant the necessary "rights, privileges, and concessions" to facilitate their general welfare and the public good. This push for institutional authority directly challenged the colonial government's ideological definition of 'qualified' practice.

Following this, Hakim Ajmal Khan organized the inaugural Ayurvedic and Tibia Conference in Delhi in 1910, bringing together Hakims and Vaids to discuss collaborative strategies. Khan urged delegates to embrace necessary reforms, adapt to scientific research, and establish modern, fully functional educational institutions to properly train future doctors (Ghaffar 1950). These conferences were far more than academic gatherings; they were strategic demonstrations of collective political strength, uniting traditionally disparate practitioners under a common banner of medical and national self-determination.

The ability of the Vaids and Hakims in Punjab to challenge colonial hegemony and organize across vast distances was inextricably linked to the strategic adoption of modern print culture. Print media served as the primary tool for mobilizing support, disseminating counter-ideology, and legitimizing traditional systems in a public, modern format (Sivaramakrishnan 2006). This was an adaptation to the commercialized and media-driven public sphere created by colonialism itself.

Vernacular newspapers and journals became the ideological battlegrounds where the debate between traditional healing and *doctory* (Western medicine) played out. Vaids utilized medical publications, books, and advertisements to constantly assert the superiority of Ayurvedic and Unani medicine over their Western counterparts. Orthodox Brahmin and prominent Ayurveda advocate Madan Mohan Malviya, using his mouthpiece *Abhyudaya*, argued that foreign drugs were not only fundamentally inappropriate for the Indian temperament but also imposed a severe economic drain on the country (Abhyudaya 1909).

Moreover, print culture allowed Vaids to modernize their professional image. Recognizing the authority that the prefix 'Dr.' conferred upon allopaths, Ayurvedic practitioners began adopting new, honorific prefixes and suffixes, such as *Professor Kaviraj Pandit Ayurvedacharya*, to signal their credentials and professional status in the public eye (Sharma 2012). This was a conscious, stylistic effort to establish parity in the community and to project authority through the mechanism of print. The widespread circulation of these claims in Punjabi towns like Lahore and Amritsar ensured that the revival was not just an elite intellectual project but a popular movement sustained by consumer choice and public opinion.

The organized resistance of the Vaids effectively constituted a counter-interpellation, challenging the ideological authority of the colonial medical ISA. By creating their own educational institutions and professional bodies (the ABAM), they established rival apparatuses that offered an alternative source of recognized medical

knowledge and identity. If the colonial state hailed a medical student as a 'subordinate servant of the IMS,' the ABAM hailed the same individual as a 'Kaviraj' or 'Hakim'—a custodian of national science.

This ideological conflict meant that Althusser's analysis of a unified, seamlessly reproducing ideology was complicated by the colonial reality. The inherent contradictions and pluralism of Indian society allowed for multiple, competing interpellations. The colonial ISA never fully achieved its goal in Punjab because the indigenous systems, backed by a powerful cultural memory and the surging force of nationalism, refused to be silenced or disappear. Instead, they used the very tools of modernity—organization, professionalism, and print—to subvert the colonial narrative, proving that ideology is not merely enforced but is constantly contested and renegotiated in the public domain.

The refusal of the Indian public to fully abandon traditional methods, even in the face of state-sponsored Western medicine, demonstrated the deep-seated popular trust in Ayurveda's efficacy, a belief that predated any nationalist fervor (Cheema 2013). This popular sentiment provided the resilient foundation upon which the revivalist leaders could build their nationalist and professional campaigns. The political and cultural success of the revival was thus a victory over the ideological project of colonialism as much as it was a professional resurgence.

CONCLUSION

The period between 1858 and 1910 in Punjab represents a foundational chapter in the history of medical sovereignty in India. The study confirms the central thesis: the colonial state aggressively utilized its institutional and legislative power to marginalize and suppress the Ayurvedic system, effectively withdrawing the state patronage that had allowed it to flourish for centuries under various Indian rulers. Policy shifts, driven by the ideological assertion of Western scientific supremacy and codified in discriminatory actions like the Medical Registration Act, posed an existential threat to the professional identity and economic viability of Vaids. These actions constituted a deliberate attempt to employ medicine as an Ideological State Apparatus, aimed at imposing a new, colonial-defined reality upon the Indian body and mind.

However, the analysis further reveals that this repression catalyzed a dynamic and politically savvy counter-movement. The Vaids and Hakims, under modernized leadership, did not merely resist; they adapted the very organizational and communicative structures of modernity to their cause. By forming pan-Indian professional bodies, standardizing training, and leveraging the potent medium of print culture, they transformed a professional defense into a national struggle. The revival of Ayurveda became seamlessly aligned with the *swadeshi* and *swaraj* movements, successfully casting the indigenous medical system as a vital symbol of national genius, cultural authenticity, and self-determination. This strategic mobilization proved that indigenous medical knowledge, far from being a relic of the past, was intellectually resilient and politically crucial, ultimately preventing the ideological closure sought by the colonial medical establishment and laying the groundwork for the system's formal recognition in the post-colonial state.

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