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Politics of Knowledge Hari M. John

If one says that knowledge has been a bone of contention between the different social classes it would only be half the truth. The fact is that knowledge has always been the preserve of the powerful and outside the purview of the poor who have had no say in it. Through the ages, those politically, socially and religiously powerful have used knowledge to subjugate and control the lives of the less powerful. The guardians of law, since the time of Hammurabi (1795-1750 BC) through the much touted Manu, the 'law giver' of India, down to the Supreme Court of George W. Bush, have zealously codified and guarded knowledge, the paths to knowledge, the structures and systems that maintain that preserve of the elite. The 'class basis' of law and legal systems present in most countries made sure of that. Denied the basic right to health and knowledge, common people through the ages have developed their own science, their own knowledge systems and skills base. One significant factor has also been the inability of the poor to pay for goods and services of any kind, especially health care, in a capitalistic economy. The vast store of knowledge and skills present in the community, to which even today 65% of the people of the orient first take recourse to before accessing western medicine, was subjugated to western systems of medicine by the colonizers. There existed then two different systems with two completely differing world views but they did not cohabit. The pursuit of cognitive justice, that is, the right of different forms of knowledge to coexist without being marginalised by official, state-sponsored forms of knowledge, as expressed, for example, by the debate between indigenous and western medical systems was the fruit of the principles of liberty, equality and fraternity from the newly emerging consciousness of democracy in much of the world in the 20th century.

To keep things in perspective:

- Professor Andrea Cucina of the University of Missouri-Colombia, while studying the remains of two men from Mehargarh in the Indus Valley made the startling discovery on studying their teeth that even from the Harappan period (circa 3300 BC), knowledge existed on medicine and dentistry ¹.
- The earliest known surgery in history was performed in Egypt around 2750 BC².
- Also, in Egypt, there was prehistoric documentation of tumours and their treatment.³
- From 2696 to 2598 BC, Chi Pai, the Yellow Emperor of China wrote his highly regarded and still widely used *Neijing Suwen* or *Basic Questions of Internal*

Medicine in which the statement was made that all blood flows in a circle⁴ much before William Harvey.

- Even more ancient than Chinese medicine is Indian medicine, first mentioned in the Atharvaveda, circa 4,500 BC and codified as Ayurveda at the beginning the Christian era.⁵
- The legendary surgeon, Sushruta wrote his treatise on Surgery and the great physician, Charaka on Internal Medicine around 1000 BC in India. Sushruta describes extensively various surgical procedures including Rhinoplasty by rotation of the forehead flap, much in the manner as it is done today, which implied considerable surgical skills.⁶
- Again, to keep things in perspective, In Upper Canada, in 1829, treatments in vogue included horseback riding for pulmonary tuberculosis, scotch snuff plaster for croup, leek poultices for gout and a decoction of carrot juice for jaundice. Dropsy was treated by bleeding, tapping and with plantain and liverwort.⁷

A Relevant Brief History of Medicine

Western medicine is largely based on Greek philosophy. Greek medicine, which was a corollary of Greek philosophy, emphasized the microcosm/macrocosm relationship between man and nature. Great attention was paid to hygiene (after the goddess Hygiea), lack of which was seen as the root of all evil. As societies developed, belief systems were replaced with a different natural system. Thales (6th century BC), Hippocrates of Cos (460 BC), considered the Father of Medicine, Aristotle (384-322 BC), Asclepades, first century BC: he was the first to hint at the atomic variation in hot and cold foods, Galen (131-200 AD), Avicenna, Ishin Ho of the Islamic school, all held the humoral basis of health and stated that improper metabolism of foods leads to disease. It was Galen that recorded the first dissections. Rene Descartes, the philosopher and physician was the one who first obtained permission from the Pope to dissect bodies and thus was the forerunner of later physicians who relied on anatomy, which, in a sense, is the basis of western medicine.⁸

But oriental systems of medicine were older than these systems by several millennia and represent complete systems of thought and practice in which the practices are derived from a whole pattern of thought about health and illness. These systems are well developed, well articulated and well established. They are internally consistent, make sense, give people effective ways of interacting with their environment and have been successfully used over millennia. A tabulated summary though brief, is illustrative of the paradigmatic differences between the older SYSTEMS (in capitals, since they are indeed complete systems of medicine) and western medicine.

Comparison of healing systems⁹

A Comparative Evaluation of Features of The Three Great Traditional Healing Systems with Western Medicine

	Ayurveda	Chinese	Unani	Western
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Place & Date of Origin	India, circa 3500 BC.	China, circa 3,000 BC.	Persia, circa 980 AD.	Europe, United States; late 19 th century.
Dynamic Elements	Prana (energy).	Chi (life energy).	Ruh (soul; spirit).	Immune system.
Diseases Correlate with	Tridoshas, prana	Yin-Yang; Chi.	Humoral imbalance.	Named pathology.
Basic Cause of Disease	Ama, the "harbinger of misery"; the cause of disease, environment, diet. Imbalance of doshas	Systemic imbalances; no overriding emphasis on one.	Imbalance of humoral temperament; Long continued errors of regimen.	Bacteria; virus.
Basis of Diagnosis	The Three problems: Tridosha: Vata, Kapha, Pitta.	Four Diagnosis of Traditional Chinese Medicine.	Humoral: Blood, Phlegm, Yellow Bile; Black Bile.	Based on patient's history, physical examination, laboratory testing.
Diagnostic Models	Concept of shiva-shakti; balance in terms of three using the tridosha.	Achieve balance of yin-passive and yang-active physiological function.	Restore balance to humors, organ systems.	Specifically named pathology.
Chief Diagnostic Modality	Differential; states of consciousness aligned with each of the three humors.	Differential, questioning, observation, palpation and listening; Zang Fu organ syndromes.	Differential; mizaj or temperament assessed for each of four humors.	Differential; named disease.
Diagnostic Tests	Tongue, pulse, urine, faeces, abdominal and palpation.	Tongue, pulse, abdominal and palpation.	Observation, lifestyle, pulse, urine, faeces, abdominal and palpation.	Urinalysis, X-rays, and standard blood tests; sampling organ tissues, injecting radio-opaque dyes, diagnostic X-rays; angiography. (Note: In the US as a whole, about 15 billion laboratory diagnostic tests were done in 2003).
Pulse Diagnosis	Correlates pulse to the tridosha or three humors. Taken by the index finger of the physician; qualities of pulse are described in terms of several animals.	Direct manifestation of the circulatory energy of the body; classical five phase pulse correspondences. Taken on the wrist; about 40% reliable as a sole diagnostic method by most TCM practitioners.	Reveals humoral imbalance in organ system. Taken with three fingers at radial pulse of wrist. More than 1,000 potential factors evaluated in seconds.	Speed: fast pulse - slow pulse.
Elements of	Five: Fire, Earth,	Five: Fire, Earth,	Four: Fire, Air,	22 Basic elements of

Nature	Water, Air and Ether.	Metal, Water and Wood.	Water and Earth.	chemistry.
Main Dietary Influences	Primarily Vegetarian	None.	Non-alcoholic; regular fasting; non-pork.	High sugar; alcohol, fats; drugs.
Will & Participation of Patient	High objectivity. Life style changes	Personal determination.	Empower patient to make changes in diet & lifestyle.	Not significant.
Primary Treatment Modalities	Pancha Karma (detoxification); herbs; diet; emetic therapies.	Acupuncture, herbs; cupping; moxibustion; diet.	Diet; herbs; fasting; cupping; purgation; baths; attars.	Chemo-therapy; pharmaceutical drugs; surgery.
Primary Treatment Objective	Clear the entire GI tract; regulate the bowels; improve digestion.	Tonification.	Mizan-restore to balance; Provoke "The Healing Crisis."	Symptom suppression; kill germs & bacteria.
Instruments Used	Glass cups.	Glass cups, acupuncture needles.	Glass cups.	Ophthalmoscope, laryngo-scope, and X-ray; moma-nometer, electro cardio-gram; MRI, Cat scan, Chemical tests of body fluids and tissues.
Side Effects	Overdose of herbal substances rare.	Potential for acute symptoms from improper needle techniques; overdose of herbal substances; rare.	Overdose of herbal substances rare.	Improper medications and severe drug reactions common; approx. 100,000 die annually in USA alone.
Population Cancer Rates	WHO Rate out of 93 Countries: 6 th lowest incidence	WHO Rate out of 93 Countries: 30 th lowest incidence.	WHO Rate out of 93 Countries: 6 th lowest incidence.	WHO Rate out of 93 Countries: 93 rd (worst of all).
Annual Per Capita Health Care Expenses	\$4.45 Source: World Bank	\$3.96 Source: World Bank	\$9.45 Source: World Bank	\$1,301.00 Source: World Bank
Common Medicines Used	Alma; goggle; Bibhitaki; triphala.	Ginseng, codonopsis, dang quai, astragalus.	Sienna pods, black seed, cumin, ginger.	Antibiotics, antidepressants, corticosteroids
Chief Complaints	Non-regulation of practitioners; lack of clinics.	Obtuse language.	Non-regulation of practitioners; lack of clinics.	Expensive; Adverse reactions; patient dissatisfaction;
Direction of Development	Training practitioners; Building schools; Develop	Integration with Western hospital medicine	Training practitioners in powers of observation;	Higher costs; more complex diagnostics; genetic medicine

	formulations, acceptance by majority		Building schools; Sources for Formulations	
Typical Cost of treatment in US\$	\$50-200	\$45-300	\$15-200	\$2,000-10,000

When such paradigmatic differences exist, to expect western medicine with its individualistic, profit-oriented, reductionist worldview to accord any sort of recognition to a completely different paradigm is illogical indeed. We are not even talking of Mediterranean medicine that predates even the above systems. Will they ever meet?

Modern medicine cannot explain the link between the “vital force” and health or disease. It cannot be seen, captured, controlled, measured, or tested by any of the instruments known to science and therefore is often thought of as no consequence. But history tells us otherwise. This “vital force” is known as chi in China, prana in India, Ki in Japanese. Hippocrates called it “vis medicatrix naturae” or nature’s life force.

Ancient Greeks, Celts, Chinese, Indian and indigenous cultures all around the world at some time in their history, practiced a form of healing which today is referred to as “holistic”, “new age”, “alternative” or “complimentary” medicine.

Whose Knowledge? Who controls it?

Where medical knowledge is concerned, three distinct phases can be delineated. The first is up to the period of Renaissance. Till then medicine was closely connected with and absolutely controlled by religion, even during the time of Hippocrates. Western medicine started from its very first onset as *medicina sacra*.¹⁰ Special emphasis, after the Christian era, was placed on *Christus medicus* as healer and the Church became *statio medicinae* or in the words of Harnack ‘*das Lazarette der menschheit* – the hospital of humanity.’¹¹

With the Renaissance, western medicine entered a new era characterized by a process of rationalization.¹² Max Weber conceived this process as the first fruit of the Reformation which liberated individuals from the past bondage of religious domination. It should be noted, however, that this liberation did not cover all citizens, specifically, the lower classes and serfs (and the lower castes in India) who were actively excluded from it. The Renaissance was also the period when western medicine started becoming individualistic and profit-oriented; and when also it was deliberately taken away from the hands of women who had largely been healers till then. Remember the witch hunts? Remember Joan of Arc?

The second period, which had a more enduring and more profound influence on human history as a whole and on medicine in particular was the age of imperialism and colonialism. Missionary medicine, combined with ‘statist’ medical systems brought an attitude of active indifference and contempt for indigenous ideas, beliefs and systems, as if there was a cultural vacuum, as if people had not thought of their own explanations for

illness and healing, a completely contemptuous world view. Keep in mind, though, that western medicine of that period was vastly inferior to established systems of oriental medicine, with proven and documented efficacy over several millennia. This attitude continues to form the backbone of health delivery systems from Bahamas to Bombay to Battambang. Around the late forties, when countless nations were becoming independent of the coloniser, there were hopes that a more-people-centered health system based on indigenous knowledge systems and be designed to serve the needs of the majority, i.e. the rural poor, the marginalized, the outcastes and such would emerge. It proved to be a complete mirage. The ruling classes, deliberately chose a health delivery system that continues to be elitist, is class-based and does not serve the needs of the majority. They are openly contemptuous of indigenous systems and practitioners. One primary reason for this would be their stranglehold over the system and its benefits such as medical schools which profit their progeny and private hospitals which mint money.

If with the departure of the colonizers we thought that power came into people's hands we would be sadly mistaken. A class of rulers who were trained in the West, thought and behaved like westerners and subscribed to western value systems and lived a western way of life, took over as rulers. It was inevitable they would choose a health delivery system based on what was present in their colonizing country – British systems in much of the Commonwealth, Dutch in the East Indies and so on. While this was inevitable, to continue to rely on these systems that have been found to be ineffective in their parent countries, speaks of a closed mindset of the ruling classes. One primary problem of course is what is practiced is the “Westminster” type of representative democracy and not participatory democracy where democracy exists in the first place. The political systems inherited and refined were redesigned to keep power in the hands of a small oligarchy. This deeply influenced health delivery systems and thus the health of the poor in much of the world. The abysmal health statistics of the third world is due, in no small measure, to this choice.

The World Health Organisation (WHO) had and still has a definite role to play. Since WHO is largely guided by the West and policies and programs are guided by those nations, it is only lately that WHO has taken cognizance of indigenous systems of medicine and started formulating policies that give a prominent role to those systems. How well these policies and programs are implemented by the member countries with their own ruling classes and with their own political compulsions will spell the success of these policies. Also to be kept in mind are the different treaties, IPR, WTO and such which have effectively whittled away the sovereignty of nations. It is well to recognize that decisions, even those affecting the health of the majority, i.e., the poor, are made not in Dakar, Delhi or Dhaka but in Washington.

Recently, in India and some other countries such as Sri Lanka, there has been a proliferation of alternative systems and for the poor and illiterate, a renewed faith in their traditional systems. The new Indian elite seems to be proud to extol the virtues of their age old wisdom but unfortunately this has been largely a part of a shift to the right in the politics of the country and again, the poor and marginalized have been excluded, confirming the belief that medicine, be it indigenous or western, is the preserve of the

elite. But people in general, are no longer equating 'scientific' with 'western' which is due to a change in the entire social and political milieu which has taken place in the last few decades.

The third and significant phase, with long lasting impact on the lives of people in general but especially of the poor, is the current period of globalisation, privatization, hegemony of the pharmaceutical corporations and the survival of the fittest. This is a difficult phase to contain because of the nexus between international and national capitalism on the one hand, and between the corporations, notably the eight or ten large ones that control seeds, food, pharmaceuticals and increasingly even water, on the other. Also, with the reign of the World Trade Organisation and unequal trade treaties such as TRIPs and GATs which are in the process of removing the safety net of public services such as public health systems, public education systems and public food distribution systems, meaningful health delivery systems for the majority are a mirage. Consider the US of A, where a significant percentage of the population, largely consisting of the poor, the blacks and the Hispanics, has no health insurance and ends up as emergency cases in hospitals across USA. This figure stands at 46 million as of 4th December 2005¹³. Where does Cambodia or Niger or Eritrea fit into this scheme of things if things are this bad in the land of plenty?

Of more concern is the hegemony of the ruling classes over information technology and the media – with the power to change the world. Who owns it? Who benefits from it? What is there for the poor of the world except images of unattainable goals?

During the pre-industrial phase, during the three phases mentioned above and indeed through much of the history of humankind what stands out is:

- i. the suppression of the rights and aspirations of the majority, i.e., the poor, the landless, the serfs, the women, the outcastes, the religious minorities
- ii. The active denial of the spread of knowledge which was limited to a small elite, be they the religious elite in the Roman Church or the Sanskritised upper castes in India.

While democratization and secularization of western medicine took place and a large number of medical schools opened, the beneficiaries were (and are) by and large the upper classes (and in India, the upper castes) reinforced by the ruling elite who continue to rule primarily for their own benefit and only incidentally for the benefit of others. For example, the medical curriculum that is implemented in Indian medical schools even today is much like the nineteenth century British medical curriculum where future doctors learn how to treat Euro-American diseases since they are destined for foreign markets. It is eloquently silent on the needs of the majority and on diseases of poverty.

Bureaucratization of Science

Unfortunately medicine, medical education, health delivery systems and such came to be bureaucratized. As science bureaucratized, knowledge lost its sense of play and was

removed from the democratic domain. Critique was taboo and even leading universities were ignorant of the works of Koyre, Kuhn, or Bachelard. As a result, when science returned to the democratic domain (as in India in the late seventies, after the Internal Emergency imposed by Indira Gandhi), the great debates on science and technology came not from academicians but from political movements. It was local struggles against trawlers, missile bases, pollution, monoculture and industrial accidents that re-created the dialogue between science and democracy.¹⁴

These struggles and movements were (and are) based on international human rights standards and the approach is to translate people's needs into rights, especially in health. The right to health is a fundamental human right and rests on various other economic, social and cultural rights, such as the right to work, right to adequate wages, right to a safe and healthy work environment, right to education, right to adequate food, right to safe, clean and adequate drinking water and so on. Article 1 of the UN Charter guarantees these rights and this was reinforced by the Copenhagen declaration of 1995.

Recently several people's movements have emerged which have become the dissenting academies of democracy.¹⁵ Some of these, in India are: the Chipko movement against forest contractors who were decimating forests, the Bhopal Gas Disaster and the continuing struggle of civil society groups for justice, the fight against Narmada dam and globally, People's Health Movement (PHM). PHM is present in 90 countries and has an active presence in about 60 of them. The fundamental demand of PHM has been "Health for all Now" and the recognition that traditional knowledge systems and indigenous medicine have a vital role to play in maintaining health, especially of the poor, across the globe, even in developed societies.

It is only by re-taking, regenerating, refining people's knowledge systems that health can be brought back into the hands of people. The everydayness of politics demands that we find more innovative ways of solving scientific controversies¹⁶ such as between western and indigenous systems of medicine. In this struggle of people to translate their needs into rights as enshrined in the People's Charter for Health (PHM)¹⁷, building and nurturing democratic people's movements and building solidarity between them on a geographically significant scale will not only lead to creativity but also to the imagination of democracy.

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