Roanne Kantor //

RK: To start, what does "medicine" mean, in the context of your work? Can you say a bit about your scholarly project?

SD: The words used for medicine in my sources are the Arabic words *tibb*, and *hikmat.* The second of these has a broader range of meaning, including 'knowledge' and 'wisdom'. It is from the root of the word 'hikmat' that we also get 'hakīm', the title for a practitioner of Avicennian medicine in modern India. My project might be considered a history of how Avicennian practitioners in colonial India wrestle with and try to redefine what medicine means to them in the age of the laboratory, mass produced pharmaceuticals, and new instrumentation. I am interested in how hakims continue to project sagacity, nobility, and the heroic healing associated with the medicine of earlier dynastic courts, in the face of the bureaucratization of Avicennian medical education and the popularization, through print publications, of its various practices of diagnosis and therapy. So, I'm also interested in the aesthetics of medical institutions and the mores of practitioners in order to trace how the ethos of gentility is instantiated in new political and social circumstances. I try to trace these changes through an institutional history of the first modern school for Avicennian medicine in India, the Madrasa Tibbiya, which was established in Delhi in 1889.

RK: How might this idea of medicine relate to the idea of translation? (for example, you work on yunani medicine, which, as you've explained elsewhere, literally means "Greek" and was developed in a cosmopolitan medieval world, but now functions in common parlance as a synonym for Muslim medicine and has very different connotations).

I have just finished translating a thick tranche of Urdu-language testimonies included in a colonial government document known as the Usman Report, the first of many state-sponsored investigations of indigenous medicine in India. One of the testimonies I was translating noted in reference to some potent medicines, "They remake the whole body; a new body is created and the old one left behind. An old man becomes young again. This is not a deception." I think this citation pertains as much to translation as to the promise of rejuvenation. It could almost be a kind of motivating self-talk to address the doubts about accuracy that a translator may have: *I am making it anew; it is not a deception*.

I have not yet come across sources that would indicate what Indian hakims in the period I study thought about translation or the work of translating. However, most of them were trilingual and constantly reading poetry and medical texts in Arabic and Persian, as well as Urdu, their mother-tongue. That having been said, Avicennian medicine, or yunani medicine, as it came to be known in

Urdu and Hindi, had no association with religious community until the early twentieth century. Kavita Sivaramakrishnan's work on medicine in colonial Punjab makes this point very well. Sanskrit medical works, as well as Arabic, were also translated into Persian, in the early modern period. Fabrizio Speziale is doing great work on this. There are also a couple of good articles in Urdu chronicling the role of Hindu men in the practice of yunani medicine. The association of 'yunani medicine' with the Muslim community in India is due to colonial knowledge projects, of which the Usman Report was one, that, despite evidence to the contrary, made such associations. The role of nationalism in reifying religious traditions and asserting the necessity of orienting the totality of everyday life by their communal compass is also important here.

RK: Your research offers an intellectual history of a location where various medical traditions are "translated" to each other (would you say that's fair?). Why do you think that's an important nexus to study? What kinds of challenges and rewards arise when different systems of medical knowledge and healing are brought together in this way?

Although I take a single medical tradition, Avicennian medicine, as a point of departure I'm also interested in tracking where boundaries between traditions are not only porous but emerge and dissolve in historically specific circumstances, and why they do so. In honing in on a single school, I am also getting a sense that what makes this tradition adhere to its past, at least in colonial India, what makes it resilient over time may be something less tangible than diagnostic practices, treatments and texts. The hakims I study in Delhi were willing to incorporate the texts, instruments, and therapies of Ayurveda and biomedicine as long as a particular ethos of gentility was preserved. I think what they felt differentiated them was a particular aesthetic sensibility, the use of particular languages, an emphasis on herbal therapies, but an elasticity when it came to diagnostic practices and even their physiology. And that is consistent with how hakims have always incorporated local mores and ideas into their practice. In the earliest days of what we call Avicennian medicine today, those physicians did not see themselves practicing an alternative tradition – they were practicing medicine. The language of Avicennian medicine was a near global lingua franca for many centuries, and its practitioners were always responding to and working according to the locality in which they lived, and attentive to the empirical practices that were most efficacious. Also, studying an analytically unruly object like Avicennian medicine in the long duree is not only a study in a locally specific palimpsest of cultural forms, but also a training in trying to be sensitive to the historically specific production of meaning. Avicennian medicine as practiced in 11th century Baghdad was different than as practiced in late nineteenth century Delhi. Not only because one is in Arabic in the middle east and the other in Urdu in India, but the local economy, new forms of sovereignty, the broader global shift in power and wealth from the Mediterranean and the Orient to northern Europe, the rise of capitalism, all of these things make medical practice in a particular place mean something different than it did previously, they are inscribed in the local story. So for me the reward is in trying to craft an argument and offering archival evidence of that inscription, and thereby demonstrating why cultural essentialism as a horizon from within which to write history is simply not compelling.

RK: As a follow up, a lot of research from anthropology (one of your areas of training) focuses on questions about culturally-mediated understandings of medicine, health, well being, and the experience of illness, especially the problems that arise when two or more systems come into contact. You are also trained in the natural sciences, whose epistemology doesn't necessarily make space for "alternative" explanatory frameworks or definitions for these terms. First, what kind of conflicts can arise in a context, like the one you study, where there is resistance to "translation" between medical systems? Second, do you ever find your various areas of training in conflict while working on this project? Does your "science brain" ever fight with your "anthro brain" or "historian brain," and if so, who wins?

I think this resistance to translation between medical systems may be a modern phenomenon and is often allied to a kind of reification of culture that attends nationalism. The Arab dynasts of 9th and 10th century Baghdad were voracious readers and translators working to their own local ends, as the work of Dimitri Gutas demonstrates; they were not invested in cultural purity. The resistance to translation, such as in Lucknow for example, a rival school to the one I study in Delhi, seems to be a way of memorializing the tradition in the face of a loss of sovereignty.

As for the disciplinary formation and its limits, I perhaps ought to say that I think not all people who practice normal science, in laboratories, clinics, etc, are the naïve positivists they are occasionally taken for. Amongst my acquaintances are people that are physicians and scientists that are very sensitive to the ways in which institutions, their own education, funding patterns, exert certain kinds of pressure to render some areas of greater interest than others. I think they are also aware of how their context furnishes them with a certain way of seeing, that makes some phenomena seeable, and knowable and not others. I think they are aware of the limits of their training and would be sensitive to alternatives to, for example, better help their patients. My point is that there are people of varying degrees of self-reflexivity, maturity, and sensitivity in all fields of work, both in the reading room and in the lab.

As far as the conflicts that emerge from disciplinary training, I think that human phenomena are complex and cannot be understood in their entirety through a single disciplinary lens. Disciplines also contain internal dissenting voices. As an undergraduate I thought I might be a psychiatrist and interned at a clinic for a year. SSRIs were becoming a mainstay of treatment and I think the word 'serotonin' had yet to enter the vocabulary of the general public. Although that biological model of depression relied on the central nervous system and the synapse as the site of physiological explanation, the clinic was also running trials on IBS, on hypnotism. There was an admission there that one biological model does not offer the explanatory power that we would like. Of course it was not within the scope of their work to consider broader social factors, or the kind of sensitivity to language that may be familiar to psychoanalysts, but they were aware of these things. Nonetheless understanding a complex problem like the current opioid crisis, for example, requires more than understanding the physiology of pain or neurotransmitters. It is no secret that in large swathes of the country there is a social concern about the loss of dignity and meaningful labour in the face of increasing automation and the globalization of supply chains. There are also pathologies amongst the one percent – why do people need to accumulate hundreds of millions and billions of dollars?

Why do people aspire to be a billionaire? That unrelenting acquisitiveness also seems like an illness to me. And these things cannot be explained only biologically, or psychologically, they also require sensitivity to deeper structural changes that are social. Each discipline has a different remit, a different scope and scale and I think the idea is to be able to see that complexity, the multiple ways a problem can be constituted.

RK: People are fond of the saying "the past is a foreign country." This suggests that it has its own culture, its own language, all of which have to be "translated" for a modern audience. As an historian, do you ever experience moments like that, when you have to translate older modes of thought about medicine and health for an audience to whom they will seems strange, or, at least, unintuitive?

I have recently been translating the Urdu language testimonies made by upper caste Hindu men that were practitioners of ayurvedic medicine in the Punjab and in Hyderabad in the early twentieth century. One of these men, Bihari Lal Jhingan, from Lahore was comparing the attitudes of erstwhile Mughal sovereigns and the British towards local medical traditions:

"Before the English rule, in the time of the Muslim kings, it is seen that the rulers of the time and the medical tradition and physicians they brought with them had no dispute with local Indian traditions. On the contrary, in those days, keeping in mind the health and convenience of Indians, the aim was adopted to spread the truth of Indian traditions, without any partiality and without any religious or intellectual prejudice. And its truth was accepted openly in the royal court. Given this, consider the citation below, which has been copied from the prefatory remarks of the book *Sikandar Shah's Mine of Healing*. …

It is worth reflecting on the matter that during the rule of Muslim kings, when the advancement of yunani medicine and the progress of its court physicians would be expected, it was considered a sin to undercut local Indian medical traditions. On the contrary, the ruling court and the royal physicians thought it their duty to spread the theory and practice of Indian medicine, keeping in mind its validity and the comfort of the people."

This citation is not about medical thought, or practice, but the politics of medical knowledge and what medical knowledge gets translated and when. Bihari Lal Jhingan was a man allied with a reformist movement known as the Arya Samaj, writing in Urdu and Persian in his testimony. That kind of multilingualism, the understated nature of religious differences, this is the sort of thing that might surprise non-historians. Jhingan, of course, is also not apolitical in his selection of material, he is using some of the language of liberalism against the British, but it is interesting that his critique of them relies on the re-assertion of this recent shared cultural heritage in early modern north India, rather than on a harking back to a genealogy of ancient Sanskrit texts, which is what one would expect.

Thanks Sabrina!