Despite its large number of practitioners, medical anthropology has given little attention to Indian homeopathy. In historical accounts, homeopathy’s popularity is explained by its position as a modern, yet non-colonial form of medicine, which became indigenized during the last 150 years. Other scholars argue that homeopathic concepts converge with Indian ideas on healing. However, few empirical data have been gathered on homeopathic practice in contemporary India. In this paper, we explore the perspectives of college-trained homeopaths in urban West Bengal. How strongly do they feel indebted to classical and canonical homeopathic writings? Can we observe attempts of indigenizing homeopathy by blending it with common ideas of Indian medical culture? While the homeopaths in our study report practising an orthodox version of homeopathy, we can also identify creative solutions when they are responding to their patients’ expectations: conforming to the idea of single-remedy prescription by simultaneous use of placebos, short-cut homeopathic anamnesis, complementing homeopathic drugs with therapeutic nutritional advice, and developing a system of seasonal drugs are all evidence for silent hybridization of homeopathic and local ideas. In the homeopathic consultation, time pressure becomes a significant challenge and Bengali homeopaths grasp the most important homeopathic symptoms quickly.

Ever since Charles Leslie’s survey of Asian medical systems in India (1976), the subcontinent has become one of the main areas for medical anthropological research. However, not all these medical systems have received the same amount of attention. While numerous studies were conducted on Ayurveda, Indian homeopathy has been largely neglected. This imbalance cannot be explained by homeopathy’s position in the Indian health care system: while the number of non-registered homeopaths is hard to estimate, the Indian Ministry of Health puts the number of registered homeopaths at 185,000, with 105,940 of them college-trained (Ministry of Health and Family Welfare 2002). In a number of states1 homeopaths outnumber Ayurvedic physicians (Bhardwaj 1980). Therefore, it is astonishing that Bhardwaj’s call (1980) for an empirical examination of homeopathic practice in India has been ignored by medical anthropology. It appears that homeopathy has escaped the anthropological
gaze as it transcends long-lasting dichotomies: modernity/tradition, indigenous/Western, colonial/subaltern.

Homeopathy reached India in the 1830s. Arnold and Sarkar (2002) argue that homeopathy was considered to be modern, while not being associated with the colonial power, as it was brought to India by non-British Europeans. Being the political and cultural centre of British India, Kolkata soon became the centre of Indian homeopathy. It was also in Kolkata where the first spectacular event in the history of Indian homeopathy took place: Dr Sircar – an already famous biomedical physician – converted to homeopathy in 1867 and started promoting homeopathic concepts in his *Calcutta Journal of Medicine*. In the 1880s, the first homeopathic colleges were founded in Kolkata, a process which was accelerated at the turn of the century. Bengali homeopaths subsequently started spreading this new mode of treatment to other parts of the country (Bhardwaj 1973).

Similarly to the nineteenth-century European context, homeopathy’s social acceptance was raised when famous patients – maharajas and colonial officials – sought homeopathic help and life-threatening epidemics – particularly cholera, malaria and the plague – were treated with homeopathic remedies. The relatively low costs for fees and remedies further facilitated homeopathy’s popularity. Attempts of professionalization in homeopathy slowly gained pace and it was not until the 1930s that homeopathic professional organizations were founded in Kolkata (Arnold & Sakar 2002). After numerous petitions, recommendations and committees, the Homeopathy Central Council Act of 1973 finally provided full governmental recognition of homeopathy as one of the seven *national systems of medicine*. Geographic distribution of homeopathic practice has remained uneven within the Indian Union: West Bengal is still a centre of homeopathic medicine and homeopathy is widespread in Uttar Pradesh, Bihar, Tamil Nadu, Kerala, while in states like Jammu and Kashmir, few homeopaths can be found (Ministry of Health and Family Welfare 2002). Homeopathy is more prevalent in urban than in rural areas (Borghardt 1990). Homeopathic college education in India is unique: four- to five-and-a-half-year degrees are offered at universities, in which basic biomedical knowledge is taught, while the focus is on homeopathic subjects. For these educational options and the sheer number of homeopaths, India has been labelled the ‘world-capital of homeopathy’ (Jütte 1996a).

In their attempts of explaining homeopathy’s remarkable success, historians resorted to two different hypotheses: it has been argued that homeopathy’s conceptual features are particularly close to Indian (medical) culture. Theoretically, homeopathic remedies should produce the very symptoms in a healthy human being which they eliminate when applied to a person with a particular disease. In homeopathy, the meaning of the term *symptom* is not limited to diseases. It rather includes all kinds of individual characteristics – such as recurring dreams, sleeping and nutritional habits – which can be signs for certain remedies. The extensive inquiry into the patients’ medical history focuses on these signs. Remedies are described in terms of symptoms, which should resemble the patient’s symptoms as much as possible. This principle of *similia similibus curentur* (like cured by like) is the central strategy in homeopathic healing. A regulating, health preserving and immaterial entity – the ‘vital force’ – is the most important point of reference in this process. Its weakening is the most important source of illness. Pharmacology is – at least in the European context – the
most controversial aspect of homeopathy: homeopathic agents are diluted until there is not a single molecule left in the final product. This is done gradually through vigorous shaking, so that the spirit of the remedy is ‘dynamized’ and becomes therapeutically useful. This process is called potentizing and dynamizing. Higher potencies (i.e. more diluted remedies) are thought to be more effective than lower potencies (Hahnemann 1921). For explaining chronic diseases, Hahnemann reformulated the concept of miasm. All chronic ailments were attributed to an infection with one of three diseases – psora, syphilis, sycosis. The imprints of these infections are passed on from generation to generation and produce increased susceptibilities for certain chronic complaints (Hahnemann 1831).

While the proximity of these ideas to Indian culture might not be instantly clear, it has been argued that homeopathy’s critical approach to vaccinations met orthodox Hindus’ aversion to animal ingredients in vaccinations (Jütte 1996a). Pfleiderer (1995) perceived the homeopathic concept of the vital force to be familiar to Indians. The similarity between Indian and homeopathic concepts have been at times overstated: the resemblance of miasm and the idea of karma (Borghardt 1990) is clearly far-fetched, as the concept miasm rather corresponds to genetics than to theories of different incarnations. Instead of being a ‘naturally’ indigenous form of medicine in Indian context, it appears that the homeopathic organizations’ claim that homeopathy is both modern and indigenous has served as a resource in their struggle for political recognition in India (Hausman 2002).

Other scholars identify an indigenized version of homeopathy on the Indian subcontinent, which has been harmonized with Ayurvedic concepts (Bhardwaj 1973; Leslie 1976). However, they stopped short of describing what a ‘naturalized’ Indian homeopathy actually contains. This is unsurprising as no ethnographic data have been collected on Indian homeopathy so far. Therefore, an empirical analysis of homeopathic practice in contemporary India appears to be a more promising endeavour than speculating about the reasons for homeopathy’s diffusion to India. In order to examine whether a specifically Indian version of homeopathy exists, we compare homeopathic practice in urban West Bengal with the homeopathic canon as well as with homeopathy in other countries (Frank 2002a). How strongly do Indian homeopaths feel indebted to classical ideas of homeopathy’s founder Samuel Hahnemann (1757–1843), such as the vital force, miasm, and single-remedy prescription? Can we identify attempts indigenizing homeopathy and blending it with common ideas of Indian medical culture? Finally, there will be a look at the clinical consultation as it is one of the most important sites where homeopathy’s actual practice is negotiated.

**Methods**

These research questions emerged from long-term fieldwork which was conducted between June 1999 and November 2000 in Kolkata by Ecks (2003). After conducting preliminary, unstructured interviews with practitioners and patients, a semi-structured questionnaire was constructed. Open-ended questions were asked in a flexible order and the option of probing into participants’ answers was used extensively. Therefore, it was possible to achieve a certain degree of comparability without
sacrificing the possibility of emerging unexpected categories. Data collection for this paper took place between February and April 2000 in Kolkata, where college-trained homeopaths were selected randomly from various suburbs. Sampling by central registers proved impossible as the Yellow Pages of Kolkata only listed three homeopaths in the city. Participation was at 100% and homeopaths expressed that they felt honoured by the visit of researchers from Germany, the motherland of homeopathy. While this high participation rate is fortunate for the research process, it also alerted us for role attribution as well as processes of social desirability (Sudman et al., 1996). It might be speculated that participating homeopaths felt examined by German researchers, who might check whether Indian homeopaths are practising in line with German textbooks. These doubts were soon dispersed as participants reported extensively about controversial aspects of their practice as well as conflicts and disagreements with their patients.

This sampling procedure led to 20 interviews with college-trained homeopaths. They were conducted either in the physicians’ chambers or their private homes and lasted between 40 and 95 minutes. The interviews were documented by a recording machine, transcribed and analysed by using cross-case as well as individual analysis (Mayring, 1988).

College-trained homeopaths usually practise in several chambers in different parts of the city. The costs of homeopathic treatment are — at approx. Rs. 50–70 for fees and remedies — significantly lower than biomedical as well as Ayurvedic treatment, which starts at around Rs. 100. However, fees can be much higher for a small number of elite homeopaths.

The homeopathic canon

Unlike in the European context, where there have been fierce disputes about whether to reconcile homeopathy with biomedical concepts or adhere to the rules set out in classical homeopathy, there appears to be broad consensus among Bengali homeopaths that an orthodox homeopathic practice along Hahnemannian principles is preferable. At first sight, they do not seem to modify homeopathic concepts at all. Homeopathy’s founder Samuel Hahnemann serves as an important point of reference in this issue — paintings or even sculptures of him are rarely missing in homeopathic clinics. In what appeared to resemble pilgrimages, several respondents travelled to Europe visiting all the places where Hahnemann has practised. How do these pledges of allegiance translate into styles of homeopathic practice?

In homeopathic anamnesis, treatment and theoretical models of healing, the state of the patient’s vital force is the most important consideration. There is no evidence for any modification of this concept among Bengali homeopaths. Regarding the weakening of the vital force as the only cause of diseases, homeopaths question biomedical notions of infections. Our participants’ responses are highly homogenous on this issue:

I do not believe in the infection. Infection is the secondary part. At first, our vitality is lost. Vital force is the basic factor. Secondary is the germs. This is the homeopathic theory, so always we insist on the increase of the strength of the
vital force. Then there will be no germs, no infection. They will be there, but they will not affect the patient. So if I treat in that way, vital force will be increased and automatically the germs will decline. Vital force will get upper hand.

(H5)

Vital force is the main thing in homeopathy. When collecting the totality of the symptoms, I particularly have the vital force in mind and then I select the medicine. That is how homeopathy works. I believe in the vital force.

(H9)

Analysing the patient’s vital force is also vital to the homeopaths’ remedial decisions. Particularly while choosing the potency of the prescribed homeopathic drug, the state of the vital force serves as the central criterion. Another aspect of therapeutic action is the number of prescribed drugs. In classical homeopathy one single drug is administered once, while its effects are observed in the following weeks and months. There are highly passionate controversies about this procedure among Bengali homeopaths. All our respondents stated that combined remedies are used in India. However, it is always other homeopaths who commit this digression from classical homeopathy.

I never use combinations. I am a very strong classical single-remedy prescriber. Give the remedy, wait and watch. Even in very advanced cases.

(H1)

I prefer single remedy. Other colleagues, they are giving several medicines.

(H9)

I have seen many homeopaths, who give 13, 14 medicines at a time.

(H10)

One respondent mentioned that he had experimented with polypharmacy at an earlier stage in his careers, even if this experience brought him back into the fold of Hahnemannian orthodoxy:

If you want to cure a person in a true sense, you have to give a single medicine. Two, three, four drugs, mixed together – you cannot cure a person. I also have experimented with giving them mixtures, but I came to the conviction that it is simply not possible.

(H14)

One participant in our study confessed prescribing combined drugs in specific cases, while another experimented with combined treatment in the past:

In most cases, I use single medicine, but in the cases in the dying stage, I give combinations of drugs. Just to ease the pain and other things.

(H6)
The norm of single-remedy prescription is of fundamental significance for Bengali homeopaths. Deviation from this rule has even been identified as the most important dilemma in Indian homeopathy. Less passionate controversies are triggered by the concept of miasmatic diseases. There is a wide consensus about the central position of miasmatic ideas in homeopathic healing, unlike in the European context where the publication of Hahnemann’s *Die chronischen Krankheiten* in 1828 led to deep division within the homeopathic community.7 There are no signs of similar debates among Bengali homeopaths and miasmatic ideas are fully embraced by them. Nearly all participants even regard miasmatic remedies as an increasingly powerful tool for treating chronic diseases as biomedical treatment suppresses the patients’ symptoms:

Miasm is very important, especially in the treatment of chronic disease. If you take a case in a proper way, it covers miasm. It is an essential part. Without miasmatic concept, one cannot remove the cause of chronic disease.

(H7)

Well, miasm is my main concept, because my grandfather studied miasm from John Henry Allen. And in the modern world of suppression, when the symptoms are suppressed and final modalities are lost, final sensations are lost. And miasm or anti-miasmatic remedies have a centrifugal action. So what I mean by centrifugal, it goes deep into the system and brings suppressed symptoms to the surface. I always include miasm in my prescribing. I cannot separate miasm from my practice.

(H1)

None of our respondents expressed any doubt about the importance of miasmatic perspectives. The precise number of miasms, however, is less clear. While Hahnemann developed three miasms, there have been attempts to introduce other types of miasm, such as the ‘tubercular miasm’. This extension is controversial among Bengali homeopaths and advocates of further miasms might be accused of deviating from the homeopathic canon:

Miasms is a very important theoretical thinking. Hahnemann has found three miasms, one from the skin disease, one from syphilis and one from the gonorrhoea disease. But tuberculosis is also a very serious disease. And a tuberculosis stigma will remain there. So tuberculosis is a miasm. So in this way, you can increase the number of miasms. It is all the diseases, which change the constitution and leave a stigma in the body. Suppose if you are suffering from typhoid, the stigma of typhoid is there. Chicken-pox might also be a miasm.

(H4)

Without the knowledge of the concept of miasm, we cannot possibly cure a single chronic case, sometimes even an acute. According to Hahnemann there are three miasms. No more than that! It should be taught to our students, to exactly follow the teachings of Hahnemann.

(H5)
Biomedical vaccinations appear to resemble homeopathic healing, as small quantities of a pathogenic substance are used. In homeopathy the aim is curative, in vaccinations preventive. While homeopathic remedies are chosen according to individual characteristics of the patients, each vaccinated person receives the same agent, which leads – from a homeopathic perspective – to suppressed symptoms. For this reason, opposition against vaccinations has always been widespread within the homeopathic community. We can expect that this view is even more controversial (and potentially damaging for homeopathy’s legitimacy) in the Indian context, as successful vaccination campaigns – such as the smallpox vaccination – have been conducted relatively recently (Ecks 2000). However, the majority of respondents report a critical attitude, particularly towards vaccinations of light diseases, which are rejected for their negative consequences on the vital force:

Unnecessarily we vaccinate our children. Even if there is no carrier in the family, they are giving also. Unnecessarily! It should be stopped immediately. There is no protection afterwards. Arthritis, skin diseases, mental diseases come after the vaccination of hepatitis B.

(H7)

I don’t recommend any vaccination in homeopathy. There are side-effects to the life-force.

(H9)

Vaccination against smallpox is usually exempted from this critique:

Medical world has started giving vaccination for every small thing. They overdid it. Homeopathy does not support this overdoing of vaccination. We are basically against hepatitis B and other things. But one vaccination we support: after the smallpox vaccination, the occurrence of the smallpox has diminished.

(H14)

Government directives on vaccinations are a source of ambivalence for Bengali homeopaths. They feel split between their homeopathic convictions and the obligation to follow government rules:

Vaccination is a very tough question to me. If you ask me as a physician, who is having binding laws by government, then I have to say: ‘Take vaccination’. If you ask me as a father, I have a different reply. I have five children. None of them has been vaccinated.

(H12)

Now, they are giving too many vaccines, making the constitution more artificial, more obstinate, more chronic. Most children are worse off after the vaccination. Whether someone asks me, whether I allow the vaccines, I say, ‘It is the common rule made by the government, I don’t ask you not to take, but I have not taken vaccine, I have not given vaccine to my daughter’. If the immune system is strong, disease will not occur.

(H11)
We are bound to refer them for vaccinations by the government. But there are so many types of vaccinations and I think it will become unaccountable. How far it has been repressive, it is a question mark. I do believe that the vaccination missions will do more harm than they do good to the person.

(H8)

Most Bengali homeopaths deal with the issue of vaccinations pragmatically, even though their appraisal is critical. While some of them reject vaccinations categorically, the majority are open to compromises in specific cases, such as smallpox. If the effects are as sweeping as in the case of smallpox, the homeopaths’ judgement is milder. Divergence from classical homeopathy is less controversial than in the issues of single-remedy prescription, miasm or the vital force. Nevertheless, we can see how the homeopathic canon – represented by Hahnemann’s writings – is highly relevant for Bengali homeopaths’ day-to-day work.

**Homeopathy in Indian medical pluralism**

A wide range of modes of treatment is practised on the Indian subcontinent. In the following, we will examine how Bengali homeopaths assess their own position within medical pluralism. As Siddha and Unani are rarely practised in West Bengal, our questions focused on biomedicine, Ayurveda and yoga. While Bengali homeopaths are highly critical of biomedicine, their attitudes towards Indian modes of treatment are less hostile. They appraise some Ayurvedic remedies as effective, even though there are no clear patterns in their assessments, which rather seem to be guided by personal experience.

In some cases, I prescribe some Ayurvedic medicine – like for constipation, some urvedic herbs are there. They act very nicely.

(H3)

Ayurvedics have got good medicine for liver-prone diseases and sex stimulating drugs, but if you know homeopathy properly, you don’t need them.

(H10)

While Bengali homeopaths value some particular drugs, they regard Ayurveda and homeopathy as completely different medical systems. This is particularly pronounced in pharmacology: contrary to homeopathic single-remedy treatment, Ayurvedic physicians prescribe combined drugs containing numerous substances. These are not potentized and therefore administered in an – from a homeopathic perspective – extremely crude dose. Ayurvedic physicians drugs are meant to work against the disease and its symptoms. Therefore, they are – literally – allopathic. That is why Bengali homeopaths appraise Ayurvedic modes of healing closer to biomedicine than to homeopathy:

Some people have tried to compare, that in Ayurveda there are three constitutional defects, homeopathy believes that there are three miasms. So they are
similar. Basically it is not true. Ayurveda is very near to allopathy as far as the principle of medicine is concerned. Homeopathy has no similarity with anyone of them. Principle of application is different, quantity of application is also different. Concept of vital force is also different.

(H14)

They are a different system. I am not blaming them, but they are giving very crude doses, but the homeopathic medicine is always giving the very fine dose. There is no similarity, because they depend on the hazardous way, like the allopathic system of medicine.

(H5)

Other participants in our study detect similarities between homeopathic and Ayurvedic approaches, while they also focus on the ‘erroneous’ mode of drug production and dosage in Ayurveda:

Ayurveda and homeopathy belong to the same mode of healing, but preparation and application is different. Vaidyas are using the same source as homeopaths, animal source, vegetable source, the same plant, they are using. But the medication is sometimes very complicated in Ayurveda.

(H11)

You see, the sources of Ayurvedic medicine and homeopathic medicine are all the same. It is coming from nature. But the applications are altogether different. In Ayurvedic medicine they are giving the crude forms of the drugs and with other sources. But homeopathy is much superior to all other systems of medicine.

(H13)

Yoga is one of the seven officially recognized ‘national systems of medicine’ of India. The majority of our respondents appraise yoga as therapeutically useful and they refer their patients to yoga teachers. For them, yoga is the most important complement to homeopathic treatment:

I have a wonderful correlation with yoga. And I do personally believe that yoga acts in the same way, even with the philosophy, you know, the dynamic energy. I believe in that. So I do take care of yogic therapy. I have a good friend with a very good yoga specialist, so I refer a lot of cases to him.

(H1)

Yoga therapy, I use – when the necessity arises – as allied treatment with my medicine. So, I allow the patient to go to a yoga therapist or tell them to do certain physical exercises for the particular trouble. For the spine, for the shoulder or particular eye exercise.

(H4)

Unlike European heterodox physicians (Frank & Stollberg 2004), none of the homeopaths in our study uses further modes of treatment in his practice. If they
appraise another mode of treatment – biomedicine, Ayurveda, yoga – as useful, they refer to the respective practitioner.

There appear to be no doubts among our respondents that homeopathy is therapeutically far superior to any other mode of treatment. Homeopathy’s advantages are manifold, ranging from the absence of side-effects to disease prevention and effective treatment of biomedically incurable diseases. Apart from chronic ailments like asthma, arthritis, digestive problems, Bengali homeopaths report treating coronary heart disease and AIDS as well as cancer:

AIDS is a disease of the vital force. Vital force is lost. I can treat it, because when the vital force is stronger, disease will be affected. When the vital force is lost, person will not be recovered. So if I can increase the strength of the vital force, AIDS can also be treated. (...) We get success. There are so many typhoid cases, which I have cured with homeopathy.

(H4)

Even in so-called surgical diseases, like tonsillitis. In allopathic system of medicine, they are telling you: ‘Oh! Cut it! Operate it!’ But in our homeopathic system of medicine, we have great success with medicines according to the constitution, so that the so-called surgical diseases can be amenable by our treatment. We can save the patients from the scalpel.

(H5)

These are no idiosyncratic opinions. The spectrum of diseases, in which homeopathy is deemed effective, is wide. Being universally useful, homeopathy appears to serve as a parallel form of general practice. Bengali homeopaths are not prepared to focus on a certain niche – e.g. chronic diseases – which has been vacated by biomedicine, but rather presents an alternative with nearly unlimited curative potential. But how reliable are these accounts? To what extent were they influenced by processes of social desirability? We have to be cautious of the responses on curing AIDS and cancer. It is conceivable that the participants tried to impress the researchers from the ‘country of Hahnemann’ (H5). However, whether AIDS and cancer can actually be cured by homeopathic treatment is a clinical consideration which cannot be answered by this study. The claim to be able to is not limited to our interviews, but present in the environment of homeopathy in Kolkata.

Homeopathic treatment and Indian medical culture

So far in our discussion, Bengali homeopaths have been described as strictly adhering to classical homeopathy. No cracks have yet appeared in their faithfulness to Hahnemannian concepts – such as miasm, single-remedy prescription, vital force – and they appear to be more purist homeopaths than their German colleagues (Frank 2002a). However, Bengali homeopaths deviate from the homeopathic canon. While they are not modifying Hahnemannian ideas, they rather include further concepts which are embedded in Indian (medical) culture: nutrition, climate, seasonal change.
These elements are not treated as external to homeopathy, but as part of Hahnemann’s heritage.

Nutrition is a prominent issue in Indian medical thinking. There is a strong concern – not only in Ayurvedic medicine, but also in popular perceptions – about the consequences of diet for people’s health (Ecks 2003). Nutrition also features in homeopathy and is a vital part of homeopathic anamnesis: quantities, particular cravings and dislikes, can be significant signs for certain remedies. Nutritional advice is not unknown to homeopathy, but only in a negative fashion: certain food can potentially reduce the drugs’ efficacy. While European homeopaths only prohibit their patients to have coffee, peppermint or camomile tea, Bengali homeopaths’ nutritional advice is much more extensive. They not only disallow numerous components of their patients’ diet, but also advise them to have specific food, in order to support the homeopathic treatment. These recommendations – which usually correspond to Indian ideas of health – might be tailored to certain diseases or include mild, vegetarian food for all patients:

I give food advice, because there is a very good relation of food and homeopathy. In case of skin disease, lobster is making some problems, some spices, crabs.

(H3)

During the treatment I give simple diet. No chilli, no rich food. It should be vegetarian food. Fruit, water and green vegetables.

(H11)

Definitely! When the patients come, I also give them dietary regulations. We give general advice, like we tell all the patients to avoid the acidic food.

(H9)

Seasonal change is a central feature in Ayurvedic aetiologies as climatic conditions are threatening the dosha balance. The relevance of the seasons are, however, not limited to Ayurvedic practitioners. Bengali homeopaths have also developed ways to incorporate seasonal change in their practice:

There is a strong impact of climate. With every change of seasons, the drug also changes.

(H13)

When the winter starts or when summer starts, some problems begin. In homeopathy, there are seasonal drugs. Hahnemann prescribed some seasonal drugs.

(H3)

In these accounts, there are clear traces of humoral pathology and prescribing seasonal drugs is clearly an innovation. This seems to contradict the orthodox approach which Bengali homeopaths reported, because they transcend the spectrum of classical homeopathic strategies by including nutritional therapeutics and seasonal drugs. Our respondents simply ascribe these ideas to Hahnemann even though they are not to be found in his writings. It seems that homeopaths defend the canonical
writings, while at the same time Indian concepts are integrated. In this way, a hybridized form of homeopathy emerges. Homeopathic elements are not isolated and replaced by others. The homeopathic canon is rather adopted as a whole and further concepts are added to it.

**Bengali homeopaths and their patients**

*The social structure of homeopathic patients*

India’s social structure is often analysed as caste-based. However, Bengali homeopaths rather use class for describing their patients’ social background. The patients’ epidemiology, their coping styles as well as their reasons for choosing homeopathic treatment are all distinguished along socio-economic lines. Diseases differ according to the patients’ class. Rich patients are said to consult homeopaths for treating iatrogenic diseases, which are caused by excessive consumption of biomedical drugs:

Upper-class patients consult too many specialists, so they come with very big files from the allopaths, having all the information. The rich class suffers more because of suppression. Recently, it has become a status symbol: ‘Just to prove how rich I am and how big I am, I have consulted all these doctors’.

(H14)

With upper-class patients, there is a lot of suppression, a lot of iatrogenic diseases. Like, if their child sneezes one time, they will take it down to the paediatrician and have something.

(H1)

Middle-class are 50–50: 50% go to allopathy and 50% go to homeopathy. They judge first: ‘This is diarrhoea, I have to go to the office tomorrow, so some allopathic tablet has to be taken to kill it. And this is rheumatism, allopathic medicine is very bad for rheumatic pain’, so they go to homeopathy.

(H4)

As biomedical treatment is seen as suppressive, upper-class patients are more prone to suppressed symptoms as they can afford multiple biomedical treatment. Affluent patients do not deal with the resultant iatrogenic diseases by abstaining from drugs, but rather by adding further – now homeopathic – drugs. Another typical reason for homeopathic consultations among rich patients are emotional problems. Poor patients, on the other hand, consult homeopaths for treating serious acute diseases:

During monsoon – in my slum clinic13 – I get cholera. And I get good results. So it is very difficult to say what exactly the limitations of homeopathy are.

(H1)

Lower-class people are suffering from tuberculosis and malnutrition.

(H7)
Apart from these socio-economic features, Bengali homeopaths report that the majority of their patients are female. Another group which is over-represented are children, who account for 30–40% of the patients. These results on socio-demographic data of homeopathic patients have to be treated with caution, as our research instrument does not produce any reliable results in this issue. Quantitative surveys would be required to obtain data that are more consistent than the homeopaths’ rough estimates presented in this paper.

Homeopath–patient interaction in Urban West Bengal

Homeopathic treatment begins with an enquiry into the medical history of the patient. This extensive consultation is supposed to enable the homeopath to perceive the entirety of the patient’s symptoms leading to the selection of the appropriate remedy. While this interaction usually takes two to three hours in the European context (Frank 2002b), Bengali homeopaths report that they do not spend more than 30 minutes on it. Follow-up consultations usually last 5–10 minutes. While our respondents reported conforming to their patients’ expectations by these relatively brief interactions, they also appraise them as a sign of their homeopathic competence. Years of experience enable them to grasp the most important symptoms directly:

I don’t have to take the long history of the patient. I am seeing 100 to 150 patients each day. So I can’t give 30 minutes, one hour to a patient. Not possible. So we have to get to an assumption of this patient after the patient has told the symptoms. And people are in such a hurry. But you see, after the practice of 40 years, the assumptions all come to us.

(H13)

It used to take two hours, but gradually, gradually, when my experience is increasing, it is now taking 30 minutes.

(H5)

It is common for Bengali homeopaths to take on assistants in their practice. In this way, the anamnesis may take significantly less than 30 minutes:

I give the patients a questionnaire and I have two assistants working for me. So they go through the booklet, they underline the books and finally, it is filled out by the patient, scrutinized by my assistant. And case well taken is half cured. I generally, to be very honest, I give 10 minutes. And five minutes for follow-up.

(H1)

It becomes evident that Bengali homeopaths do not aspire to build a strong personal relationship during these first consultations. By employing assistants and questionnaires, the formal procedure is strongly rationalized, so that it might be hard to distinguish from biomedical interactions. However, their contents are still specific to homeopathy. Particular requirements on the patients’ side have to be met when homeopathic knowledge is translated into practice. Again, our respondents categorized their patients in socio-economic terms. Poor patients often lack the ability to verbalize their bodily symptoms – skills which homeopaths depend on in their
attempts of healing as detailed verbal accounts of homeopathic symptoms are the most important path to remedial decisions. In order to translate sensations into language, a sufficient level of education is required, which lower-class patients do not always possess:

Here, many people are illiterate. They cannot explain the symptoms. So if I ask ‘What type of pain?’, they say ‘Pain is there!’ They cannot explain the type of pain, burning pain, stitching pain or growing pain, because in homeopathy 8–12 types of pain are there. I have to find out the actual type of the symptom.

(H3)

In case of lower-class patients, I take the help from the body language. There we are going to see the exact thing. The more sophisticated, the more intellectual, the more the body language is controlled. It is very difficult to take the case in the upper-class in this way. But in the lower-class, their body speaks more than their words. From there, we catch our clue for prescribing.

(H12)

We ask about a headache: ‘What is the character of the headache?’ The answer comes: ‘I don’t know’. Bursting headache, burning headache or stitching pain?

(H1)

Additionally, not all patients agree on the structure of homeopathic consultations. The contents of homeopathic communication might diverge from their ideas of an appropriate conversation between medical specialists and patients. Some of the broad issues raised by their homeopaths are perceived unnecessary:

Some patients are laughing. Like if I ask about some dreams or ask if they have salt or not, they say: ‘Why are you asking such type of questions?’

(H3)

If it is a new patient who has come to try homeopathy, they wonder: ‘I have come with pain in my leg. Why are you asking how am I passing my bowels and about my sleep?’

(H10)

Often, the patients don’t know what sorts of questions the doctor will ask. They don’t come prepared for that. When they hear our questioning, they will feel confused.

(H14)

This difficulty is even more pronounced in mixed-sex consultations as homeopathic questioning covers intimate territory at times:

We have to ask leading questions. Especially with the ladies, it is difficult. They are ashamed with a male doctor. So when the ladies come, it is a problem. They are very hesitant.

(H9)
The time frame of the interaction poses another source of disagreements between homeopaths and their patients. While the duration of homeopathic consultations does not appear to be excessive from a European perspective, Bengali patients are said to regularly complain about the amount of time it takes their homeopaths to arrive at a remedial decision.\(^{14}\)

> Sometimes the case-taking\(^{15}\) is taking long time – they are getting annoyed with this.

\[(H13)\]

> Some of the people who live a very fast life and who are accustomed to going to a doctor and telling them ‘Oh I got a fever’. and immediately the doctor writes the medicine. Those people find it difficult, because they don’t understand why it is important to ask so many questions.

\[(H14)\]

Bengali homeopaths frequently encounter difficulties when it comes to exploring the miasmatic background of diseases as this takes a long time. They describe their patients as impatient, so that regarding potential miasmatic sources in treating acute diseases becomes impossible:

> In my experience, in case of chronic cases, miasm is needed, but in acute cases, there is no need for miasm. If I ask the patient, ‘This? This? This?’, they get fed up: ‘Come on! I have a cough! Give me some medicine!’

\[(H3)\]

One of our respondents even distributes a booklet (\textit{What the Doctor Must Know to Make a Successful Prescription}) among his patients in order to make them comprehend his seemingly unlimited curiosity. In this way, patients are socialized for the extensive communication during anamnesis.

Patients appear to expect homeopathic consultations to be speedy processes – a surprising result given that the survival of non-biomedical forms of treatment in India is often attributed to a particularly time-consuming, meaningful relationship between practitioners and patients, in which psychosocial issues can be discussed (Nichter 1981; Nordstrom 1989). Our data suggest the opposite: patients do not demand the kind of consultation Nichter describes and Bengali homeopaths are under pressure to arrive at their prescription in a process as brief as possible.

\section*{Perceived patients’ expectations}

In interviews with a cross-section of the population (Ecks 2003), we were surprised by the wide distribution of homeopathic knowledge among the general population. Many interviewees were able to name the origin and the founder of homeopathy as well as a few homeopathic remedies. This homeopathic literacy can be explained by the popularity of homeopathic self-help literature during the last century and by the strong position of homeopathy in the Indian health care system. While German homeopaths usually try to conceal the name of the remedy they prescribe (Frank...
2004), the medication is less disguised in West Bengal as the patients receive their remedies in homeopathic pharmacies. The high amount homeopathic knowledge, particularly among educated patients, leads to controversies during the interaction. Sometimes the patients know the characteristics of a prescribed remedy thoroughly enough to challenge the homeopath’s decision:

In this country, everybody knows about homeopathy. You go out on the street and people know. And then he gets the prescription like Nux Vomica 200, which perhaps he had been given before. Sometimes they give me a look and I am saying: ‘You might have had Nux Vomica, but you haven’t had my Nux Vomica’. I have to say, they know the ins and outs. They will tell you: ‘Nux Vomica? But I do not have that symptom, because I read about Nux Vomica’. I get very literate patients who are conscious about homeopathy.

(H1)

If the background is there, sometimes we have to explain: ‘Why you are giving this medicine?’ Maybe the patient has taken this medicine before without success. So, he may know the medicine.

(H13)

The open prescription can lead to processes of negotiation, in which homeopaths have to defend their decisions. A very different path is pursued with another form of medication: the use of placebos. All our respondents support prescribing placebos to their patients. They write a prescription which includes a code (arcana or 0 as potency) which can only be deciphered by the pharmacist. The patients then receive a placebo instead of a homeopathic remedy. Our respondents justify this strategy by their patients’ expectations:

Here, people have got the idea: ‘If I take more drugs, I will get better’, because they are habituated to taking many allopathic medicines. Like when they take antibiotics, they take vitamins also.

(H3)

In case of chronic cases, I use placebos. Like bronchial asthma or different kinds of eczema, I will give high potency, high power. So I have to wait 60 days for the next medicine. In between the 60 days, I have to give the placebo for the mental satisfaction of the patient. I say, ‘This medicine, you take morning and evening’. With homeopathic medicine, it takes time. That is the main problem.

(H8)

Placebo is very well, because the patient wants medicine. If not necessary, even then he wants medicine. They are mentally satisfied with taking medicine. If I give the patient one dose and ask him to come after one month, the psychological effect will be there: ‘One medicine for month. What will happen? I will die. Disease will be increased. Doctor has not given me medicine’. Psychologically they will suffer.

(H4)
It is the only way of satisfying the patient, because they are thinking they are taking the medicine. In some of the cases, they don’t need any medicine, but I never tell them: ‘Well you don’t need any medicine’, because they would see another doctor! Unnecessary! That’s why we close the chapter by giving placebo. Sugar and milk. This is the best policy and they are getting satisfied with you. They will be happy. Placebo to please the patient. If you don’t give any medicine, patient will feel uncertain whether he will be cured or not and think: ‘Oh it is better to switch to another doctor and take some more medicine’.

(H5)

Homeopathy is not exempted from Indian patients’ desire for multiple medication which is well documented by anthropological and public health research (Greenhalgh 1987; Kamat & Nichter 1998; Sachs & Thompson 1992). These expectations are in sharp contrast with homeopathic modes of healing as only one drug should be given exactly once, followed by the observation of its effects. Daily use of placebo drugs is the only way out of this divergence of perspectives as a strictly homeopathic procedure would not satisfy the demands of patients who would seek help elsewhere. As multiple medication is essential, homeopathic treatment in West Bengal appears to be a highly pharmacological event in which communicative aspects are less significant.

Conclusion

For those medical historians examining homeopathy in nineteenth-century India, the most fascinating issue appears to be how India could possibly become the ‘world’s capital of homeopathy’ (Jütte 1996a). Unlike biomedicine’s diffusion to India which can be explained by colonial processes, homeopathy has reached the subcontinent without any powerful economic or political agents contributing to it. Homeopathy’s success in the Indian context has been explained by the convergence of knowledge systems as some details of homeopathic concepts – vital force, anti-vaccination attitudes – appear to resemble aspects of Indian (medical) culture. At first sight, our data appear to support this notion as the participants in our study report practising an orthodox version of homeopathy. However, the idea of knowledge convergence clearly seems to be overstated and areas in which homeopathy contradicts Indian medical culture are neglected in this perspective. By investigating the expectations which Bengali homeopaths perceive among their patients, areas of divergence become more salient. That homeopaths complain about impatient patients is not a surprising result, but rather one of the best-documented characteristics of the health-seeking behaviour on the Indian subcontinent (Nichter 1980; Wolffers 1988). As homeopathy is shaped by a strong thirst for knowledge, time pressure becomes a significant challenge. Bengali homeopaths have to grasp the most important homeopathic symptoms quickly. If their demand for time and information is excessive, their patients will seek help elsewhere. Another area in which homeopathic concepts collide with the Indian context is medication. Despite widespread knowledge on specific homeopathic remedies, homeopathic strategies of using them appear to be less known and patients demand multiple remedies. In their attempts of putting homeopathic knowledge into practice, homeopaths are acting in an environment
consisting of their patients’ expectations and the norm of homeopathic orthodoxy. We can identify creative solutions to this tension: Conforming to the idea of single-remedy prescription by simultaneous use of placebos, short-cut homeopathic anamnesis, complementing homeopathic drugs with therapeutic nutritional advice, and developing a system of seasonal drugs are all evidence for silent hybridization of homeopathic and local ideas. Bengali homeopaths report compliance with homeopathic orthodoxy and innovations are incorporated in the homeopathic canon. The homogeneity of our respondents’ answers on their adherence to classical homeopathy implies that purism also serves legitimizing purposes within the homeopathic profession. We can speculate that the orthodox norms among homeopaths might be caused by their standardized college-training as well as their desire to distance themselves from less qualified homeopaths.

Homeopathy has established itself as a strong force in the Indian medical scene. Homeopaths refuse to focus on particular fields of medicine, but rather claim to heal a wide spectrum of ailments and show little inclination for complementary models. Therefore, homeopaths appear to aspire to the status of general medicine which can potentially cure all kinds of diseases. The economic framework of homeopathy in India contributes to this claim. Unlike in the European context, homeopathic treatment is significantly less expensive than biomedicine and Ayurveda. Homeopathy becomes affordable for large parts of the population, so that economic considerations may be involved in their choice for homeopathy. While this paper focuses on the practitioners, homeopathic patients’ perspectives are explored elsewhere. To complement these qualitative studies with data on the patients’ socio-demographic and epidemiological characteristics would be beneficial, but a lot more work remains to be done. As homeopathy has always been particularly popular in Kolkata, homeopathic practice styles are surely not representative for the Indian Union and comparative studies with other parts of the country are needed. Additionally, a closer look – possibly by participant observation – at the system of homeopathic educational institutions would shed light on how Indian homeopathy is socially reproduced. These further studies might enable us to increase our knowledge on one of the most enigmatic events in medical history: homeopathy’s diffusion to India and its consequences for medical practice in contemporary India.

Notes

1 There are 15 times more homeopaths than Ayurvedic physicians in West Bengal.
2 Even nowadays, homeopathy is often called German medicine, as opposed to English medicine (biomedicine).
3 In the German context, there are official documents showing that the mortality rate during the cholera epidemic (1831/1832) was significantly lower in areas where cholera was predominantly treated by homeopathy compared to regions in which biomedicine was used. This cannot serve as an ultimate proof for homeopathy’s efficacy as this apparent success might be due to the fact that then biomedical recommendations for cholera – such as bloodletting or the prohibition of drinking water – were simply avoided by homeopaths (Jütté 1996b).
4 The other six are biomedicine, Ayurveda, Unani, Siddha, naturopathy and yoga.
As there are few hospital beds available for homeopathic patients, homeopathy is mostly practised mainly in settings of private practices (Schumann 1993).

There is little importance given to aetiology in homeopathy.

Miasmatic treatment is less significant for homeopathic practice in contemporary Germany (Frank 2002a).

Homeopaths reject biomedicine for the side-effects of its drugs as well as its inability to cure the roots of patients’ diseases. Only diagnostic technology, surgery, and emergency medicine are valued. This issue is explored more thoroughly in Ecks and Frank (2004).

The term allopathy was introduced by S. Hahnemann (1831) in order to distinguish homeopathic concepts of healing (like cured by like) from biomedical ones. While the term carried negative connotations during the nineteenth century, it has been established on the subcontinent as the common name for biomedicine, having by and large lost all traces of its mocking undertone.

Ayurvedic physician.

However, it has not been able to enter Leslie’s (1976) list of medical systems in India.

In Ayurveda, health is maintained by balancing three *doshas* (vata, pitta, kapha). Any disturbance of these *doshas* will result in diseases.

It is not uncommon for Bengali homeopaths to do charitable work in slum areas for a few hours of the week.

German homeopathic patients even clash with their physicians as they demand more time than the two to three hours provided by their homeopath (Frank 2002b).

Commonly used term for anamnesis.

Reimbursement policies in health insurance schemes make biomedicine the cheapest mode of medicine available in Western countries.

Ecks and Frank (2004).

References


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