Journal of Ayurveda and Integrative Medicine 7 (2016) 57–61

Contents lists available at ScienceDirect

Journal of Ayurveda and Integrative Medicine

journal homepage: http://elsevier.com/locate/jaim

General article

Challenges of mainstreaming: Ayurvedic practice in Delhi Government health institutions

Sharmistha Mallick*

Department of Sociology, Kamala Nehru College, University of Delhi, New Delhi, India

ARTICLE INFO

Article history:
Received 29 April 2015
Received in revised form
29 June 2015
Accepted 31 October 2015
Available online 24 May 2016

Keywords:
Ayurveda
Bureaucratization
Mainstreaming
Medical pluralism
Public health

ABSTRACT

This paper is an attempt to understand the project of mainstreaming in India's health care system that has started with an aim to bring marginalized and alternative systems of medicine in mainstream. The project has gained much attention with the establishment of Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) in the year 2003, which is now a ministry. It has ushered some positive results in terms of growth of AYUSH hospitals and dispensaries. However, it has also raised challenges around the theory and practice of mainstreaming. With an emphasis on Ayurvedic practice in Delhi Government Health Institutions, this article has tried to analyze some of those challenges and intricacies. Drawing on Weber's theory of bureaucratization and Giddens's theory of structuration, the paper asks what happens to an alternative medical system when it becomes part of the bureaucratic set-up. Along with the questions of structures, it also tries to combine the question of the agency of both patients and doctors considered to be the cornerstone of the Ayurvedic medical system. Although our study recognizes some of the successes of the mainstreaming project, it also underlines the challenges and problems it faces by analyzing three points of view (institutions, doctors, and patients).
© 2016 Transdisciplinary University, Bangalore and World Ayurveda Foundation. Publishing Services by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

1. Introduction

The mainstreaming of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) as a policy commitment of Government of India gained a renewed importance with the establishment of a separate Department of AYUSH in 2003. After that, a positive impact has been observed in the growth of almost all AYUSH services. In the following developments, several state governments such as the Delhi Government started making budgetary allocations for something that they had brushed aside until then. Though export of Ayurvedic medicines, raw drugs, and expertise has been the main thrust of the central Department of AYUSH, a new insertion started with the inclusion of alternative therapies. Further, the establishment of National Rural Health Mission (NRHM) in 2005 [1] made a crucial impact. The NRHM aims for an integrative health structure in which AYUSH systems of medicine and Western medicine would together serve the people in the public health system [1–3].

Mainstreaming, as defined by the Department of AYUSH, refers to “integration of infrastructure, manpower and medicines of AYUSH systems to strengthen the public health care delivery and strengthen the AYUSH systems at grass root level by establishing a linkage with western medicine in a collaborative way” (Department of AYUSH is a central government body, now Ministry of AYUSH, which is working primarily for the mainstreaming of AYUSH in public health care system). The integration of quality AYUSH services in the public health care system by co-locating them with allopathy is to provide a choice of treatment to the patients, especially those who are dependent on government health facilities. The Ministry of AYUSH aims to promote AYUSH systems at the grassroots level by improving outreach and quality of health delivery in rural areas. Many scholars [4,5] see it as an adjustment. Shankar [6] views this mainstreaming as “functional integration” in which allopathy and AYUSH systems functioning together under one roof. In his view, in the future mainstreaming will lead to a new pluralistic regime of “integrative medicine.” Mainstreaming, in Weberian ideal-typical form, involves the encompassing of alternative medical systems in the bureaucratic form of social

* C/o-Dr. B. K. Choudhary, Room No. 90, New Transit House, JNU, New Delhi, 110 067, India.
E-mail address: sharmistha.mallick@gmail.com.
Peer review under responsibility of Transdisciplinary University, Bangalore.

http://dx.doi.org/10.1016/j.jaim.2015.10.001
0975-9476/© 2016 Transdisciplinary University, Bangalore and World Ayurveda Foundation. Publishing Services by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

organization [7]. This mainstreaming refers to the incorporation of alternative medical services that were hitherto organized in relation to social and community demands and that were without centralized control, into the bureaucratic system of state administration and market mechanisms. Drawing on Giddens's idea of structuration [8], this paper looks at Ayurvedic Health Institutions as social structures that were considered important aspects of providing and defining health and illness. Moreover on the other, the study has looked at doctors and patients' views to consider the question of agency in health and illness, which is grounded very much in their socioeconomic and cultural contexts. The process of mainstreaming has raised important questions such as: what kinds of changes have the medical systems undergone? What does this say about state regulation of medical pluralism? How do patients make choices seeking in government hospitals? These questions draw the subject under sociology of medicine, which enquires into the complexities of mainstreaming in relation to its social context.

The sociological study of alternative systems of medicine in contemporary India requires an understanding of medical pluralism and its different facets, namely, popular, scientific, administrative, and interpersonal. The idea of medical pluralism developed in the countries of the global South where a biomedical monopoly of health care has been a rule. In this context, Minocha [9] has discussed how alternative approaches, strategies and programs have tried to rectify the biomedical domination. Leslie [10] and Khan [11] have suggested for a contextual research for medical pluralism in terms of a critical analysis of the issues of power. Bhardwaj [12] argues how this medical pluralism is resulted in increasing degree of professionalization, systemic articulation of the Indian medical systems. Sujatha [13] shows how the overemphasis on identifying effective pharmacological formula from Indian System of Medicines and standardizing them undermines their internal structures of folk medical knowledge. The NRHM report [1] discusses the dangers of integration of AYUSH with dominant health service structure because of their different worldviews, philosophical frameworks and logic, different conceptions of the body and mind, and different theories of physiology, pharmacology, and pharmaceutics. The report rightly points out that integration in the present Indian context is one sided in which there is the only integration of AYUSH systems with allopathy. The integration of allopathy with AYUSH is not happening in a similar way. Sujatha and Abraham [4] have raised some immediate concerns with regard to medical pluralism in contemporary Indian society. By co-locating AYUSH practitioners in Primary and District Health Centres, the aim is to provide allopathic services in remote areas which does not amount to any recognition of AYUSH systems' therapeutic value. This argument is helpful to understand the crucial linkages of public-private partnership and the nature of the relationship of Indian systems of medicine with the state in the 21st century. Priya [5] argues that each knowledge system has its own merits and in public health, a method needs to be developed to bring together these systems. She argues that AYUSH systems are relevant for public health not only due to their therapeutic value or their utilization by a large section of the underserved but also because they represent principles of quality practice and ethics that can be learnt and incorporated within the health system to the benefit of all. Shankar [14] advocated for integrative health care to make public health care system more pluralistic in nature. He argues that integrative healthcare appears to be the future framework for healthcare in the 21st century that involve radical changes in medical education, research, clinical practice, public health and the legal and regulatory framework.

However, the above-mentioned theoretical and analytical models often confront other problems when it comes to the level of practice, for example, lack of detailed diagnosis, irregular medicine supply, and lack of basic infrastructural facilities. In this paper, I have tried to problematize the idea of "mainstreaming" focusing primarily on the aspects of practices.

2. Methodology

This article is an outcome of author's fieldwork in eight standalone and co-located Government Ayurvedic Health Institutions of Delhi in the years 2008–2011. It has been observed that mainstreaming has different connotations in different spatial contexts. It is also assumed that mainstreaming has shown a positive result in metropolitan cities as compared to rural areas because of the better health facilities available in metropolitan cities. Several studies have underlined this achievement [1]. Being a national capital, Delhi works as a model for policymakers as well as scholars trying to understand the impact of policy implementation of mainstreaming. Delhi also shows several strands of mainstreaming that is rarely possible to observe in other places. A city with huge migrant population also reflects on the values and associations based on which people decide their medical choices. With public and private co-located and standalone institutions and urban and semi-urban constituents, Delhi becomes a rare site to observe the intricacies of mainstreaming.

The study is done in eight Ayurvedic institutions (among eight Ayurvedic institutions, three standalone and five co-located Ayurvedic institutions have been selected for the study.) under the central, state, and municipal governments. The sample institutions were selected mainly in the urban and semi-urban areas of Delhi on the basis of institutional origin and their status as standalone or co-located institutions as well as their location in Central, State and Municipal Government Institutions. The study compares Ayurvedic Health Institutions at two levels: Central, State and Municipal Institutions and standalone and co-located institutions under these government bodies. Comparing Central, State and Municipal Health Institutions, the Central and Delhi Government Institutions (both standalone and co-located) have relatively good quality services as compared to municipal institutions. Again, the standalone Institutions of Delhi Government and Municipal Corporation of Delhi (henceforth MCD) are qualitatively better as compared to co-located health institutions. The similarities and differences between institutions are analyzed on the basis quality of Ayurvedic services such as classification of disease, method of diagnosis and treatment, patients' strength, the social background of patients, the source of medicines, and epidemiological data of patients.

The sample of informants within the selected institutions was chosen purposively with an aim to find the difference in Ayurvedic health services from the perspectives of institutions, patients, doctors and other officials in the context of mainstreaming and medical pluralism. In every institution, with regard to patients' interviews, 30 out-patient interviews (both standalone and co-located) and 10 in-patient interviews (standalone) have been taken. With regard to doctors, in standalone Ayurvedic institutions, three doctors' interviews from each Ayurvedic specialization and in co-located Ayurvedic institutions, three Ayurvedic and two allopathic doctors' interviews have been taken. Among other officials, head of the institutions such as medical superintendents and deputy medical superintendents, paramedical staffs, nurses, attendants, have been interviewed. Besides this, a large mass of out-patient department (OPD) data were collected from these institutions to carry out an analysis of the patients, their background and complaints.

Despite offering some new insights in the fields of sociology of health and medicine and public health, the study recognizes some of its limitations. One faces these limitations because of different institutional structures, variations in numbers of patients, huge

infrastructural gaps, and even different approaches of individual doctors and patients toward health and medicine.

2.1. Mainstreaming and administrative practices

Mainstreaming of AYUSH systems of medicine involves their inclusion into the bureaucratic framework based on the hegemony of medical experts and administrators. In this respect, AYUSH systems of medicine come to acquire the same problems that allopathy has developed due to its bureaucratization. The elements and common problems associated with mainstreaming of Ayurveda, medical pluralism and bureaucratization can be seen in terms of a comparative perspective of Ayurvedic Health Institutions in Delhi. It is found that Central Government Ayurvedic Institutions are performing relatively better in terms of infrastructure, resources, medicine supply, the salary of the staffs and patients' strength than State Government and Municipal Institutions. Wherever the health services are better, in general, both the allopathic and Ayurvedic services are also better [1,4,5]. The major reason is that the budget is proportionately high for Central Government Ayurvedic Institutions than the State and Henceforth MCD Institutions, cited by the heads of Ayurvedic institutions.

A comparison of standalone and co-located Ayurvedic institutions in the study shows that the standalone institutions have better health facilities as compared to the co-located institutions. The comparatively better health facilities also show the difference in patients' strength in standalone and co-located institutions. In standalone institutions, the patients' strength is higher than in co-located institutions. This is because first, in standalone Ayurvedic institutions, there are different specialties for Ayurveda such as *Kayachikitsa* (medicine), *Shalya* (surgery), *Panchakarma* (rejuvenation therapy), *Prasuti* and *Striroga* (obstetrics and gynaecology), *Kaumarbharatya* (pediatrics), *Shalakya Tantra* (eye and ENT). Second, standalone Ayurvedic institutions have surgical and pathological laboratory facilities and indoor admissions for patients. As compared to standalone Ayurvedic institutions under Delhi Government, standalone Ayurvedic institutions under MCD have poor maintenance of the building and irregular medicine supply.

The comparison is further made between all these institutions in terms of the source of medicine supply. The companies from where they purchase the medicines are the same. This is because one company supplies medicine to all these institutions, all are affected by similar problems like the irregular supply of medicines, and the patients are left with no option other than purchasing medicines from the market. MCD Ayurvedic Institutions as compared to Central and State Government Ayurvedic Institutions have a serious lack of medicine supply where the medicines have not been supplied to these institutions for the past 6–8 months.

Interactions with the medical superintendent, deputy superintendent and principal of Ayurvedic Hospitals and Medical College makes it clear that over the period, the budget for Ayurveda as compared to allopathy in public health care system is low. The low budget for Ayurveda, as per these authorities, has resulted in a lack of infrastructure, irregular medicine supply, lack of hygiene, irregular salaries, and lack of proper staffs. There are no specialized paramedical services. In standalone institutions, the pathological laboratory is sometimes dysfunctional for months at a time and often they only take blood samples in the name of pathology. Procedures such as ultrasound and electrocardiogram have to be done from outside. In almost all MCD Institutions covered in the study, even the examination table is not properly functional. In MCD Institutions, there is no toilet facility for the patients and only doctors and paramedical staffs use the toilet. Some co-located MCD Institutions lack even a signboard indicating the presence and location of an Ayurvedic Department. The poor infrastructure in MCD Ayurvedic Institutions, both standalone and co-located, is a result of not even having chairs and tables for the doctors. In the name of *Panchakarma* treatment in standalone institutions, they have only *Purva karma* such as *Snehana* and *Swedana*, which is only a small part of *Panchakarma*. In Ayurvedic standalone institutions under Delhi Government, out of 150 indoor beds, only 50–60 are functional. The hospital buildings, in general, are very old and have not been renovated in the last 60–70 years.

2.2. Patients in Ayurvedic institutions: the question of "choice"

Whereas a comparative perspective of Ayurvedic institutions gives an insight into the problems associated with mainstreaming and medical pluralism in general, the case histories of patients, in particular, help us analyze the question of "choice" under mainstreaming and medical pluralism. To argue further, how far the mainstreaming of Ayurveda by the Indian Government is able to provide poor people better "choices," which the government is aiming in the name of mainstreaming and medical pluralism.

For patients in Government Ayurvedic Hospitals and dispensaries, *sarkari* connotes free medicines and cheaper treatment. Patients in different Government Ayurvedic Institutions of Delhi view Ayurveda as *desi dawai*. All patients interviewed in the study believe in only one binary, that is, *desi and angrezi dawai*. (*Desi dawai* is referred to all alternative therapies and *angrezi dawai* is used for allopathy by the patients visiting Ayurvedic health institutions.) For them, all alternative medicines come under *desi*. From the accounts of patients, it is found that the reasons for choosing Ayurveda as an option for treatment are diverse. Among the interviewed patients, most of them have come for Ayurvedic treatment after trying all the possible options in different government and private hospitals. The point is that their choices are not informed by cultural consonance with Ayurveda rather they consider Ayurveda as one of the alternatives to allopathy. For some patients, Ayurveda is just another medical option. No matter whether it is Ayurveda or allopathy, the most important factor for them is availing medicines free of cost. For some others, the choice is made because Ayurveda Departments are less crowded. Few others consciously opt for this medical system as it has fewer side effects. This also goes against conventional anthropological view of Indian patients seeking Ayurveda for ethnic and cultural reasons and shows that the meaning of Ayurveda for patients is not uniform for all and that it comes from their socioeconomic locations.

Most of the patients, in Ayurvedic institutions, have rarely observed any difference between Ayurvedic and allopathic diagnosis. For them, both Ayurvedic and allopathic doctors ask about the main complaint, the duration of illness and give symptomatic treatment. Both the doctors also see pathological reports or prescribe tests for patients. This situation seems true for all the government institutions that are covered by the study. In Government Health Institutions, on the one hand, there is demand for Ayurveda in the disorders such as digestive disorder, paralysis, piles, hypertension, joint disorder, etc. The lack of basic infrastructural facilities and the availability of quality medicines on the other reduce the demands of Ayurveda. Patients most often have to buy medicines from private pharmacies outside the institutions that are not affordable for them. The major reason for the dissatisfaction among *sarkari* patients is that they do not get all the prescribed medicines from the hospitals and dispensaries. The average cost of medicines for patients is much high in the institutions in which the medicinal supply is scanty.

2.3. Situating Ayurvedic doctors in public health setting

While looking at the problems of mainstreaming and medical pluralism, it is essential to analyze the role of Ayurvedic doctors who become part of modern health care system. First, the process of deprofessionalization of Ayurvedic physicians that is discussed through Weber's theory of rationalization. Weber in his theory of rationalization argues that the modern doctor's role is conditioned by professional norms, values and work requirements that are confined to the norms and standards of the bureaucratic hospital set-up. According to Weber, changes in large scale structures and institutions are exerting increasing control over physicians and impelling medicine and its substantive rationality in the direction of greater formal rationalization. Doctors become cogs in the bureaucratic machine that handles large numbers of people, but the doctors' autonomy, and relations with patients are gradually undermined. This ultimately leads to deprofessionalization of physicians. For instance, in the study, in bureaucratic health set-up, one can find the erosion of Ayurvedic physicians' substantive values such as their autonomy, control over patients and altruistic values. These changes involve increasing impact of bureaucracy on physicians [7].

On the basis of observations and interactions with doctors, doctors in both standalone and co-located institutions try to negotiate with the bureaucratic health setting at various levels. They diagnose patients as per the requirements of the various illnesses that patients are suffering from. They apportion more time to inpatients than outpatients. If the average patient load in standalone hospitals per doctor is 90–100 to be seen in 3 h, then it may not be possible to give more than 3 min/patient. The doctors in co-located institutions spend 3–5 min on an average per patient as they see about 30–40 patients in 3 h. Thus, the serious scarcity of doctors in the public health services and very low levels of government investment in extending medical facilities has led to overcrowding in hospitals.

Our field studies clearly indicated that the claims made by doctors in both standalone and co-located institutions in Delhi about Ayurvedic principles of diagnosis and treatment were not borne out in actual practice. Whether standalone or co-located, an Ayurvedic doctor gives very little time to patients. No detailed enquiry made into history, background and origin of disease for the patient. They prescribe medicines after about 1–2 min of enquiry into the problem, with questions like "*kya hua hai aap ko*" (what happened to you) or like "*kya dikkat hai*" (what problem you have) or "*kab se hai*" (since when). Sometimes, before patients finish talking, doctors prescribe medicines and ask the next patient to come in. If a patient asks many questions like "*doctor saab*, *mujhe pet dard ke saath saath sar bhi ghum raha hai*, *uske saath ghutne me bhi dard ho raha hai*, *bhukh nahi lag rahi hai*," *doctor bolte hain* "*yeh dawai le lo*, *thik ho jayega*" (doctor, my stomach hurts and my head is reeling. I have severe pain in my kneecap and I do not feel like eating. After hearing such a complaint, the doctor would simply reply, "take this medicine, everything will be ok"). In this short duration of time, doctors depend on patients' own accounts to explain their disease situations, instead of deducing it on their own. Patients repeatedly point out that the doctors prescribe medicines even without doing a complete enquiry.

When asked about how Ayurvedic treatment ought to be done, the Ayurvedic doctors explained that in an illness situation, *aahar* (food), *aaushadh* (medicine) and *vyavhaar* or *vihar* (dos and don'ts or precautions like exercise) are suggested to patients. On whether they actually do this, some doctors said that it is not possible for them to do detailed diagnosis and prescribe *aahar* and *vihar* for each patient and that this also happened in the case of allopathy. The method of detailed diagnosis and treatment depends on the number of patients that they have to treat each day. In the gynecology OPD, for instance, in pregnancy or in poly cystic ovarian disease case, we observed that they took the menstrual history, previous childbirth if any, is there any miscarriage in the past, and advised the patients to take ultrasound test as it was not previously done. Ultrasound tests are advised to examine the ovaries to see the development of fertility eggs. After all the tests are done, the treatment is given.

In the case of ailments such as piles, detailed history and anal examination of the patient were conducted to check for hemorrhoid, swelling, pain, redness, inflammation, or bleeding in the anus. The Ayurvedic doctors ask questions in which the digestive system, as food habits or intake of fruits, is mainly emphasized. They ask if the patient has constipation and whether there is bleeding or color found in stool. If there is bleeding, they check if the level of hemoglobin is low. They also ask the patients to go through tests such as hemogram, total leukocyte count, differential leukocyte count, erythrocyte sedimentation rate. Before doing surgery, the patient is normally admitted for 2–3 days and after surgery, for 1–2 days he/she is admitted. Moreover, they prescribed antibiotics to avoid infection. The surgery for piles is done through the special procedure called *ksharsutra*. (*Ksharsutra* is a surgical procedure in Ayurveda for the treatment of fistula-in-ano. In this, a medicated cotton thread of special variety is prepared by soaking in herbal preparation and is tied/inserted in an area to cut, drain and heal of the fistulous track. In ayurveda, *ksharsutra* is a medicated thread which is prepared by applying the coatings of *apamarg kshara*, *haridra churna* etc. with *snuhi ksheer* as binding agent.)

In terms of medication, all doctors in these institutions with few exceptions said they give Ayurvedic treatment to their patients and that they do not prescribe allopathic medicines at all. Acute cases like complications in delivery and surgical emergencies are immediately referred to allopathic practitioners. One or two doctors interviewed explicitly said they prescribe allopathic medicines in cases like fever, ailments that require surgical intervention and pre- and post-natal delivery cases. To their knowledge, Ayurveda does not have pain killers and anti-biotics. Some doctors said few patients want different diagnosis and treatment in Ayurveda due to their dissatisfaction with the previous mode of treatment, particularly allopathy. However, in Ayurveda, they do the symptomatic treatment at the first instance depending on whatever the patients describe their symptoms. Hence, this shows that contemporary Ayurveda in public health care system being based on the symptomatic treatment of disease is not able to give attention to the clinical investigation of patient and detailed case taking as it should be doing. On the other hand, it is found that there are few doctors in standalone and co-located institutions who did listen to the patients' complaints carefully. One can also find instances in both public and private institutions where Ayurvedic practices are fulfilling patients' needs satisfactorily.

3. Conclusion

The paper while looking at the paradox of mainstreaming from varied angles, such as institutions, patients and doctors, has arrived at some general conclusions. It is found that neither the patients are able to get the best treatment nor is the integrity of Ayurvedic medical system being maintained in actual practice. In a metropolitan city like Delhi, the claim of contemporary Ayurveda as having a holistic approach toward medication needs to be contested. The major problem thus does not lie in a particular medical system as such, rather in the context in which the system is situated

and the approach toward health care that governs this situation. Second, it can be argued that mainstreaming has just created a mildly inferior version of allopathy by setting up co-located institutions to serve the dominant medical system. This is even true of standalone Ayurvedic institutions. No doubt that mainstreaming has made it possible for Ayurveda to be accessed and availed by poor people in Delhi city, whereas in the private sector it is only accessible to the upper strata of the society and this is by no means a small achievement. But, the question is about providing quality health services because Ayurveda is now reduced to an adjunct therapeutic system and it exists in the form of about 30 odd company made medicines that are handed out by the Ayurvedic doctors. Fomentation, fresh herbs, herbal decoctions are lost, even as medication many things have disappeared in Ayurvedic practice. Often the medicines in the form of tablets and capsules are also indistinguishable from biomedicine. Irrespective of the difference felt by the patients, we may consider efficacy as a criterion. However, efficacy is difficult to assess for any system in the public arena including allopathy as people always resort to multiple therapies at the same time.

While one can see the scope of medical pluralism in co-located institutions, the study shows the larger politics where pluralism is practiced without challenging hierarchies. The equal choices which medical pluralism aspires for in a pluralistic health setting are thus missing. Medicine or any medical system *per se* cannot be viewed without the patient as a primary interlocutor. Health policies must focus on patients, practitioners and officials, not as equal actors rather the patient with their social baggage should be brought into the center. The politics of negotiation and mediation also needs to be seriously questioned because the serious issues of health and medicine should not become the matter of negotiations or matter of available choices rather a matter of right. This also points out that the issues of mainstreaming of Indian medical systems must be situated in the context of structuration of health care set-up.

Source of support

Nil.

Conflicts of interest

None declared.

References

[1] National Rural Health Mission. Report of the survey on status and role of AYUSH and local health traditions under the NRHM. New Delhi: National Health Systems Resource Centre; 2010.
[2] Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. India towards Univers Health Cover 2011;377:505–15.
[3] Dummer TJ, Cook IG. Health in China and India: a cross-country comparison in a context of rapid globalisation. Soc Sci Med 2008;67:590–605.
[4] Sujatha V, Abraham L, editors. Medical pluralism in contemporary India. New Delhi: Orient Blackswan; 2012. p. 1–34. Introduction.
[5] Priya R. AYUSH and public health: democratic pluralism and the quality of health services. In: Sujatha V, Abraham L, editors. Medical pluralism in contemporary India. New Delhi: Orient Blackswan; 2012. p. 103–29.
[6] Shankar D. The challenge of integrative medicine with special reference to NRHM. Health for Millions. New Delhi: VHAI; 2008. Available from:, http://www.vhai.org/ceo/current_focus.php [Last accessed on 10.03.15].
[7] Ritzer G, Walczack D. Rationalization and the deprofessionalization of physicians. Soc Forces 1988;67:1–22.
[8] Giddens A. The constitution of society: outline of the theory of structuration. Cambridge: Polity Press; 1984.
[9] Minocha A. Medical pluralism and health services in India. Soc Sci Med 1980;14B:217–23.
[10] Leslie C. Medical pluralism in world perspective. Soc Sci Med 1980;14B:191–5.
[11] Khan S. Systems of medicine and nationalist discourse in India: towards "New Horizons". Soc Sci Med 2006;62:2786–97.
[12] Bhardwaj SM. Medical pluralism and homeopathy: a geographic perspective. Soc Sci Med 1980;14B:209–16.
[13] Sujatha V. Pluralism in Indian medicine: medical lore as genre of medical knowledge. Contrib Indian Soc 2007;41:169–202.
[14] Shankar D. Health sector reforms for 21st century healthcare. J Ayurveda Integr Med 2015;6:4–9.