

## BRITISH RESPONSES TO TRADITIONAL MEDICINE (TM) IN COLONIAL CEYLON (SRI LANKA)<sup>1</sup>

This essay continues the discussion given in *Wellcome History*, Spring, 2004 on the interactions between western (allopathic) medicine (WM) and traditional medicine (TM) in colonial Ceylon (Sri Lanka). The term Traditional Medicine, as used for example in WHO publications, is preferred here to Indigenous Medicine, as used in the *Sessional Papers* of the British colonial government in Ceylon, because the all-encompassing term Indigenous does not differentiate the other components of TM from the truly indigenous component *Desiya Chikitsa* (local medicine) that is the oldest component of TM in Sri Lanka.

The British colonisation of Ceylon from the end of the 18<sup>th</sup> century to the mid-20<sup>th</sup> ended with the entire country under its rule encompassing the economic, political as well as social aspects in Ceylon, and the interaction between TM and WM that the British introduced, was thereby greater than during the Portuguese or Dutch occupations.

Official publications on colonial attitudes to TM in Ceylon are meagre though there is more written on TM in India. Commentaries by individual Western and Indian authors on the Indian context regarding TM and Western Medicine (WM) are quoted here because there appear to be parallels between the Indian and Ceylonese contexts, especially because of cultural, sociological and (colonial) administrative similarities between the two countries and above all because TM as practised in Ceylon is largely of Indian origin.

Until about the mid-nineteenth century during British occupation Western and indigenous systems of medicine peacefully co-existed with the latter's pluralism, humoralism and pharmaceutical practices, till the second quarter of the 19<sup>th</sup> century (Worbhoys 1993; Wear 2004) and the Europeans regarded TM positively as a potential source of new drugs and medicines. In the early decades of British rule in India, "...they set out to learn as much as they could about local drugs from the Indian practitioners, and they studied the local plants for their medicinal properties" (Patterson 1987; Wear 2004).

In later decades however, especially with advances in Western Medicine (WM), British patronage of and support for indigenous medicine appears to have waned. In India, "[f]or the greater part of the eighteenth century most Europeans

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were contemptuous of Indian medicine and science” (Patterson 1987; see also Wear 2004 on a similar situation of the Spanish in the Americas).

In Ceylon, “While the colonial administration took special interest in protecting the health of the British Army and the administrative personnel as soon as they conquered the island, they neglected to provide even the bare minimum for the colonial labour force” (Hewa 1995). *Lancet*, also remarked in an editorial (Anon. 1996) on comments of Dr. Patrick Manson on the “vast benefits” that would “accrue to natives” in setting up diplomas in Tropical medicine in the UK; “[t]he truth of the matter is that the discipline was exploited by the Colonialists in order that the health of British personnel, both overseas and following return to the UK, could be improved”. With the expansion of plantations, economic interests also became important and hence the health of the plantation workers in addition to that of the militia was paramount; the indigenous population was of interest to the British through its contact with the military personnel (Arnold 1988). The British promoted their colonial interests with their system of medicine while TM had no state patronage; “[s]tate recognition given to Ayurveda was gradually withdrawn” (Ranasinghe 1987).

Negative views were also expressed on TM in Ceylon by John Davy F.R.S., a Doctor of Medicine and member of the Royal Army’s Medical Corps from 1816-1820, and the brother of Sir Humphrey Davy; “[s]urgery... is in an extremely rude state...knowledge of pharmacy is equally limited ...their physiology... is of the most fanciful kind” (Davy 1821). Apart from Davy’s “...examining the uses and qualities of the peculiar natural productions abounding in that fertile and hitherto little investigated Island” (Sir Humphrey Davy’s letter to the Secretary of State, seeking his approval for the appointment of John Davy as Physician to the forces in Ceylon), and on his researches in physiology and anatomy, there is no record of his investigations into the Island’s indigenous medicine. In addition “[t]hose doctors serving the *Raj* believed their professional status to be under threat should they make too many concessions to indigenous medicine or modify training to take account of local conditions and languages” (Stewart 1991). A further constraint on the interaction between WM and TM arose from prohibitions against mutual collaboration from the Medical Councils of WM.

The feeble interest of the British official personnel in TM is reflected in the British colonial government’s official records, the *Sessional Papers*, which were reports submitted to the Legislative Council of Ceylon. Between 1855 and 1947 (92 years), 3133 papers were tabled. Of them only 3, in 1927, 1936 and 1947, were on ‘indigenous’ medicine (two having been sequels to the first in 1927), contrasting with numerous papers on aspects of Western medicine (83) as well as on archaeology (42), agriculture and plantations (61), botany, education etc., in the colony.

The neglect of and indeed opposition to TM engendered by the official British colonial policy was in marked contrast to the great interest shown by British colonial administrators as well as by British individuals, in archaeology and the natural sciences in Ceylon. "No one should fail to remember with gratitude the services rendered by the Colonial powers who were responsible for overseeing the protection and preservation of ancient monuments... The Colonial authorities admired all such works and the people of the Island were reawakened to behold, admire and wonder at the sight of the creative genius of their forefathers" (Wijesekera 1990). It is not surprising that there were numerous writings of the colonial British administrators on subjects such as archaeology contrasting with the paucity of their official documentation and writings on TM.

From the late eighteenth century to the early nineteenth century, Europe experienced great social, political and industrial changes together with an upsurge of interest in Indian history and culture. Sanskrit writings especially in mathematics, medicine and astronomy were translated into European languages for the first time. There were also some Western students of Oriental knowledge who had a positive approach to TM, but the writings of most of them were particularly in the fields of religion, philosophy, and archaeology. "These men were the Orientalists, the first serious British students of Indian culture....They were rationalists, classicists and cosmopolitans for the most part and, put simply, they believed that both races in India had much to give each other" (Moorhouse 1971). In India, for example, Whitelaw Ainslie published a book in 1826 (London, Longmans) "*Materia Medica or some account of those articles which are employed by the Hindoos and other Eastern nations in their medicine*". In Ceylon, *The Journal of the Royal Asiatic Society (Ceylon)* has articles on anthropology, zoology, botany, ethnology, flora, Buddhism, geology, ornithology, and indigenous languages, but it is curious that indigenous medicine *per se* was not a subject that Western authors wrote much about although botanical aspects of medicinal plants were written on by R. Bentley & H. Trimen (1880) and by T.H. Parsons (1937). H.C.P. Bell, the Archaeological Commissioner, who set up the Ceylon Department of Archaeology during British colonial times, documented the best evidence, from an archaeological perspective, for a mediaeval hospital in Ceylon. J. Liyanaratne, (Liyanaratne, 2001, personal communication) who has written extensively on the literature on Sri Lankan TM is also of the view that "...Britishers have not written much about the traditional medicine of Sri Lanka". In his compilation of translations of Sanskrit medical treatises, Zysk (1984) also commented: "While manuscripts on Ayurveda are numerous, in the past there has been little scholarly work on the subject....". Unfamiliarity with the indigenous languages was not the reason for the paucity of writings by Orientalists on indigenous medicine: Fort William College in Calcutta, India, which "became the focal point of intellectual activity among the

British...published more than a hundred original works in oriental languages... The time was not far distant when Mr. Lockett, the Chief Librarian, could boast that he supervised the largest collection of orientalia in the world; the Escorial had 1,851 volumes, Oxford 1,561, the Seraglio in Constantinople 7,294; but Calcutta, in 1918, had a grand total of 11,335 printed and manuscript sources” (Moorhouse 1971). Sir Whitelaw Ainslie published a list of twenty-one Sanskrit medical writings known to the Sinhalese and Tamils in the early part of the 19<sup>th</sup> century. Further evidence of the Westerners’ interest (despite the paucity of their writings) in indigenous medicine is the numerous 19<sup>th</sup> and early 20<sup>th</sup> century manuscripts written in the indigenous languages in Sri Lanka (Sinhala, Sanskrit, Pali), which are now deposited in European libraries – the Bibliotheque Nationale and the Musee de l’Homme in France, the Bodleian Library in Oxford (Liyanaratne 1992), Cambridge University, the India Office Library, The Royal Library in Copenhagen, Denmark, and The British Library in London which has Hugh Nevil’s collection (1904) of 2227 items which include scripts on medicine and science.

Despite extensive authoritative writings by colonial Britishers on Orientalia, for example, the Asiatic religions and their philosophy, archaeology, botany, zoology, anthropology, sociology, ornithology in Ceylon, the number of writings on TM are far less. Goonetilleke’s comprehensive bibliography (Goonetilleke 1973) of Sri Lanka lists only 18 articles on TM by Western authors, written during the colonial decades; these 18 included 1 listing of TM literature, 11 which described TM therapeutics, 3 descriptive of TM and only 3 which were analytical of TM. The writings on TM by Westerners, however, were more descriptive than analytical, and dealt especially with TM’s herbal therapeutics rather than with the theoretical bases of TM. Some reasons for the Westerners’ low interest in TM may be considered.

Explanations for the paucity of writings on and interest in TM could include the fact that **the** source material on TM lay in texts written in Asian languages, Sanskrit and Sinhala with which colonial doctors might not have been familiar. The ‘Orientalists’ however, familiarized themselves with these languages in the course of their personal studies (eg. the translation from Pali to English of the Chronicle of Ceylon, *Mahawamsa* by Wilhelm Geiger). In archaeology, on the other hand, on which copious writings by Western officials, including British authors, also appeared, the source material – ruins, statuary, paintings – were readily observable, but needed conservation, analysis and interpretation.

Secondly, Britain had prior experience of archaeology for at least 200 years; they had the methods and the organizational experience, and their first activities in Ceylon were a survey and description of monuments (R.H. de Silva, 2000, personal communication).

Thirdly, some British officials of the Raj had a literary background, for example H.C.P. Bell, an early Commissioner of Archaeology in Ceylon, was a

scholar in the Classics, A.M. Hocart, a successor to Bell, was an anthropologist. Perhaps TM was a radically different paradigm to the British while Ceylon's archaeology, though in a different historical and cultural context, fitted into archaeological theory and practice with which they were familiar.

While TM did not develop in British colonial Ceylon, contributions to health and medicine under Western medicine during this period included compulsory vaccination, establishment of municipalities and local bodies of health, restrictions on the use of opium, regulation of the sale of poisons and intoxicating liquors, medical aid ordinance for the plantations, registration of births, marriages and deaths, quarantine, and inquiries into outbreaks, e.g. of cholera. Such innovations in public health through Western medical approaches, clearly, contributed to the view of their superiority, a fact even acknowledged by practitioners of TM in India, especially because preventive measures for dealing with epidemics were absent at that time in TM, and hence the establishment of WM was vital for development of health services in Ceylon. It is noteworthy that, in Ceylon, the *Sessional Paper* of 1927 recorded that "The recent outbreak of plague at Galle originated in cases attended by Ayurvedic physicians, who failed to diagnose the disease as infectious, and failed to report it as such". Thus it was especially during the later decades of British colonial rule, when Western medicine achieved great advances in theoretical knowledge, as in knowledge of the microbial causes of disease, that the confrontation between TM and WM was at its greatest. A point (G.H. Peiris, 2001, personal communication) that deserves consideration is that colonialism might also have brought into sharper focus, the differences between TM and WM in respect of their efficacy, with changes in the morbidity pattern that occurred under the impact of socio-economic and demographic transformation brought about under colonial rule. These changes could have been related to diet, personal habits and certainly to the importation of 'new' diseases such as yaws, small-pox, venereal diseases and cholera, not only with the influx of colonial personnel but also with large numbers of immigrant labourers imported for the colonial plantation enterprise. TM might not have been able to cope with these 'new' diseases, whereas TM therapies, which are still well-known for their efficacy, dealt with, for example, orthopaedic problems which probably existed through the centuries, especially from injuries in battle in Sri Lanka.

It should be recorded that, *pari pasu* with the feeble support of TM by the colonial government, WM was enthusiastically acclaimed by the local western-educated intelligentsia: "We have to be grateful to a paternal government for the deep interest it has always taken in the health and well being of the people, and for its efforts to remove and mitigate evils or causes of disease and mortality" (Vanderstraaten 1886).

“The decay of Indian medicine, as Majumdar puts it, was due to the ‘greater importance attached to Western medicine introduced in this country during British rule’ “ (Bala 1991).

The low support from the British government for TM was also expressed in the unsuccessful attempts to resuscitate TM in Ceylon. There existed a local “Oriental Medical Society” which had been offered by the government, one year previously, a site for the establishment of a TM college and hospital; the trustees of the Oriental Medical Science fund “mooted the idea of establishing an ayurveda hospital”(Uragoda 1987). Members of the committee that drafted the *Sessional Paper* of 1927 were of the opinion that about “75% of cases were treated by Ayurvedic practitioners”; this figure accords with Simeonov’s data (Simeonov 1975) gathered 50 years later. It is significant that even the Governor of the colony stated “a very large percentage of the population of the colony...attached the greatest importance...and reposed the highest confidence” in “native” medical treatment (*Sessional Paper I*, 1927).

The Society had insufficient funds and the offer was withdrawn. Nor was there official financial support for the resuscitation of TM. The lack of government funds for TM contrasted with the considerable expenditure on other ‘scientific work’ e.g. promotion of Western medicine, archaeological conservation, agriculture, and botanical studies.

The *Sessional Paper* of 1936 stated: “The Government was unwilling to undertake the responsibility for establishing such an Institution” (a college and hospital for training indigenous medical practitioners) “for the Government was committed on a very large scale to the fostering of the Western system of medicine”. With increasing westernization during the 19<sup>th</sup> century, there occurred “a complete reversal of the early liberal attitudes of Europeans to Indian culture, including medicine.... In 1883, the Grants Commission reported that the Indian medical colleges should be abolished, and all support for Indian medicine withdrawn (Patterson 1987).

The concomitant arrival of British Christian clergy in both India and Sri Lanka could probably have further eroded the popularity of TM as their activities medical might have been successful in weaning the public from their reliance on traditional methods of treatment, although in remote areas in 18<sup>th</sup> century British India where there were no WM doctors, missionaries called in TM practitioners because they had some appreciation of indigenous systems of medicine (Roy 1972). That this transference of reliance from TM to WM did occur is still to be shown but it would appear to be in the vein of Lord Macaulay’s prescription for the colonized natives of India that while remaining Indian in blood and colour, (they) must be English in tastes, opinions, in morals and in intellect. The role of proselytizing western clergy was not restricted to religion but probably spilt over to TM as well

because the indigenous medical traditions had a heavy underlay of their religions, especially Buddhism. The close links of TM with Buddhism in ancient Sri Lanka are evident from the fact that: "All the ancient hospitals as well as medicinal troughs so far discovered in Sri Lanka are associated with Buddhist monasteries" (Mahinda 1997), while Zysk (1991) concluded that "Buddhism played a key role in the advancement of Indian medicine through its institutionalisation of medicine in the Buddhist monastery". In 1928, during British colonial times, an editorial in the *British Medical Journal* (Anon. 1928) commented on the: "...Buddhist practice of founding hospitals;..." and that "It is to Gautama (Buddha) and his followers that we owe, apparently, the hospital idea". Some data quoted by Richards & Gooneratne (1980) might be indirect evidence of the shift from TM to WM with urbanization and westernization. For example Table 1 modified from their document shows the proportion of rural and urban people [of the lowest (poorest), middle and highest (richest) socio-economic classes] who availed themselves of health care from TM (Ayurvedic) and WM sources in the government and private sectors, with the provisos that TM facilities are scarce in the government sector though readily available in the private sector where also TM is cheaper

**Table 1. Sources of health care (percentages) for different socio-economic classes of urban and rural people in Sri Lanka #**

<i>Among the poorest class</i>			
Sector	type of care	urban (%)	rural (%)
Government *	WM	45 (90)	50 (90.9)
	TM	05 (10)	05 (9.1)
Private **	WM	35 (74.5)	17 (44.7)
	TM	12 (25.5)	21 (55.3)
* p = 0.874 NS			
** p = 0.005 S			
<i>Among the middle class</i>			
Government *	WM	42 (85.7)	53 (89.8)
	TM	07 (14.3)	06 (10.2)
Private **	WM	31 (70.5)	20 (55.6)
	TM	13 (29.5)	16 (44.4)
* p = 0.513 NS			
** p = 0.168 NS			
<i>Among the upper (richest) class</i>			



Government *	WM	40 (87.0)	51 (89.5)
	TM	06 (13.0)	06 (10.5)
Private **	WM	40 (80.0)	25 (64.1)
	TM	10 (20.0)	14 (35.9)

\*  $p = 0.692$  NS

\*\*  $p = 0.093$  NS

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# modified from Richards & Gooneratne 1980 (quoting the *Socio-economic Survey, Dept. of Census & Statistics 1969-1970*).

While these figures do not directly answer the question whether westernization (and hence a possible conversion from Buddhism to Christianity) was accompanied by the shift from TM to WM, they suggest that among the poorest rural people (who might be considered to be less westernized than the upper, richer, urban classes), the significantly higher preference was for TM. Although the corresponding percentages for the middle and upper classes showed a higher percentage for the rural people, these differences were not statistically significant.

For the same reason, that is the close relationship between TM and Buddhism, the later revival of TM was linked to the general revival of indigenous culture, as in the Indian parallel: "Since indigenous medical knowledge was linked with the culture of the past, the move to resuscitate the Ayurveda and Unani could be seen as a part of the rising national consciousness" (Bala 1991). The threat to indigenous or traditional medicine (TM) was thus pronounced during the British colonial times and, as Arnold (1998) wrote: "The very nature of late nineteenth-century (British colonial period) medicine contributed to this far-reaching medical interventionism. Seeing itself as rational, scientific and universalistic, western medicine defined itself in opposition to the presumed irrationality and superstition of indigenous medicine. The customs and beliefs of the people were treated as obstacles to be overcome, obscurantism to be brushed aside by the new scientific age".

There were, however, occasional official views that were appreciative of TM; in India it was stated that "...there are also many tracts of merit, we are told, on the virtues of plants and drugs, and of the application of them in medicine...there is much good in the Ayurvedic system, and there can be little doubt that for many years to come the majority of Indians will continue to be treated by this method" (Bala 1991).

Despite the paucity of their writings on indigenous medicine, the Orientalists in India, notably Sir William Jones, showed much interest in TM, which indeed led to the establishment of the Native Medical Institution in 1822. William Jones was the founder of the Asiatic Society of Bengal, the pioneer of Indian studies,



and the “undisputed founder of Orientalism” who had a high regard for Indian culture.

The *Sessional Paper (Ceylon)* of 1927 quoted an Indian document on the need for the support of the Government of Madras (India) for TM: “The Western system of Medical treatment reaches only a very small fraction of the rural population, and there is little prospect of any material improvement in this condition within a reasonable period. Whether the indigenous system is scientific or not, the bulk of the population has to depend on them (*sic*) for medical relief ...”. This appears to be a cogent reason for support of TM, even in contemporary Sri Lanka.

In summary, some explanations for the waning interest in and increasing opposition on the part of the British to TM might include the following:

(1) Rapid advances in natural and physical sciences, with the ‘Scientific Revolution’ were occurring in England during the 19<sup>th</sup> and 20<sup>th</sup> centuries. By the 19<sup>th</sup> century, medicine in the West, as a part of its science, was also developing rapidly, especially in preventive medicine, vaccination, the handling of epidemics, the aetiology of disease, and therapeutic procedures. WM was therefore considered by the British government to be more useful for the health care of its personnel, notably the militia.

(2) Conversely, the colonial administrators and doctors did not see any procedures in TM at that time which were superior or had at least some degree of efficacy, in such areas of medicine as listed in (1). Yet it must be recalled that practices in hygiene were well developed in ancient Ceylon, as evidenced by elaborate hospitals, sanitation, drainage, which are documented in the archaeological literature. In later, especially colonial, centuries during which plague, small pox and cholera appeared in epidemic proportions, such ancient knowledge was not used, perhaps because this knowledge did not relate to these ‘new’ diseases; it was left to Western approaches, such as the Rockefeller enterprise (Hewa 1995) to control these diseases. On account of the predominant concern of the British colonial government for the health of its personnel, both military and civil administrators, and for the local persons who interacted with them, WM was used for this purpose. There was some justification for the British view on the superiority of WM over TM as “...spectacular successes in public health policies (which) were not found in the Indian context” (Bala 1991).

(3) A further explanation for the low interest in TM by the colonial government could relate to colonial policy and governance. Archaeology, indigenous flora and fauna, anthropology and sociology which were extensively studied and written on by British personnel, might be considered to have been culturally and politically, relatively neutral topics; these topics, were academically and historically remote from the contemporary British colonial times, and did not interact with colonial governance, while TM especially with its intimate links with

Buddhism and indigenous culture, that were regarded by the British in opposition to WM and western culture, entered into cultural conflict in British colonial times especially when WM as a part of Western science was used as a 'tool of Empire' (Headrick 1981; MacLeod & Lewis 1988) in legitimising the spread of Western culture and colonial expansion. The "... impetus for an ongoing development of tropical medicine was thoroughly imbued with the economic and political objectives of British imperial policy" (Hewa 1995). In assessing the impact of imperialism on the medical profession in India, some Western writers view WM as a means for consolidating colonial rule. To that extent, WM served as a 'tool of Empire', essentially in political and economic terms. Even during the Spanish colonization of the Americas, "... it was in the interests of the Spanish that their own culture and medicine should appear superior to those of the peoples they conquered"... and that "It was also in the nature of the colonial enterprise to subvert and destroy those aspects of the indigenous culture that threatened European supremacy and authority. As a result, there was little regard in Spanish circles for Aztec medical knowledge, which was rarely discussed in those works published in Europe describing the new world" (Wear 2004).

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