MEDICINE AND SOCIETY IN SRI LANKA

An authoritative study of the history of medicine in Sri Lanka, published to commemorate the centenary of the Sri Lanka Medical Association, fills a long-felt lacuna in our information on a subject which has hitherto been confined to fugitive research papers and episodic notes. The work under review,* is particularly welcome in view of the unique qualifications of the author to undertake the task. It is rare that a leading consultant physician also has to his credit a number of publications on various aspects of medical history, ancient and contemporary. No history of medicine can, of course, claim to be "complete". Some selection is necessary. Consequently many titles listed in the comprehensive *Bibliography of Medical Writings on Sri Lanka 1811-1976*, co-authored by Dr. Uragoda, do not find a place in the present book. It is understandable that the author has paid more attention to his own areas of interest in the present carefully researched volume. One need only mention his articles on ancient health care and healing practices, particularly the institution of hospitals, anciently and in Dutch times, the practice of immersion in milk, oil etc, acupuncture-related techniques, religious and occult approaches such as the chanting of *pirit* by monks, the fabrication of talisman and amulets in addition to materia medica, as well as medical aspects of the pearl fishery and the opium trade.

Medical history, properly so called is no longer a narrative of events occurring in temporal sequence. Nor is it the codification of disease-patterns or medical topography over a period of time, pioneered by early British physicians such as Henry Marshall (1821). The facts, considered in their socio-cultural context, present a number of problem areas which fall within the scope of the emerging

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* C.G. Uragoda. *A History of Medicine in Sri Lanka - From the Earliest time to 1948.* A Centenary Publication. Colombo. Sri Lanka Medical Association (1987) p. 326, Bibliography, 26 Maps, Plans, Plates. Rs. 300/_.

discipline of medical sociology. These include such phenomena as professionalization, the structure of institutions such as hospitals and asylums (designated total institutions by Erring Goffman[1]), the doctor-patient relationship, the role of para-medical personnel, and diseases arising from adoption of new life styles, especially in urban areas. An example is the incidence of diabetes mellitus. The disease had been identified in the indigenous tradition, and various herbal remedies commonly used. But the incidence of diabetes assumed serious proportions among the affluent rentier or landlord class and the sedentary middle class, which arose as a result of structural changes in the colonial economy under British rule. The "luxurious indolence" of the urban rich, and the "wonderful corpulency" they attained was the subject of comment by the American physician, Samuel Fiske Green, who pioneered medical education in the Mission Hospital in the North, in an observation recorded in 1854[2]. Likewise, the consumption of toddy and arrack in the coconut areas the fermentation and distillation of which were expressly forbidden by the Kings, led to an increase of diseases such as dropsy and liver cirrhosis deriving from alcoholism. Malaria was always with us, but the stagnant waterways remaining after the exodus from the Dry Zone provide ample breeding ground for the malaria-carrying mosquito, and there were "malaria stations" which public servants dreaded to serve in, despite the availability of quinine, mosquito nets, and citronella oil. The situation improved after extensive spraying of DDT by the British army during World War II, and the anti-malaria campaign launched by the government.

A recurring problem of medical history in Sri Lanka was that western medicine was not implanted in a vacuum -- there was a pre-existing corpus of theoretical or conceptual and empirical medical knowledge, partly deriving from the Sanskritic Great Tradition evolved by authorities like Susruta in medical centres such as Varanasi. On the other

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1. In his pioneering study *Asylums* Penguin books 1968.

2. Samuel Fiske Green. Beloved Physician, in *Images of Sri Lanka through American Eyes* ed. H.A.I. Goonetileke. Colombo (1975).

hand there was an indigenous "little tradition" comprising discrete collections of empirical knowledge in palm leaf "handbooks" (*at pot*) jealously preserved as family secrets by distinguished practioners. Some of these palm leaf manuscripts have been retrieved and published by the Department of National Museums, particularly one on opthalmology. Sinhala medicine (*Sinhala vedakam*) predated the reception of the Sanskrit tradition, had less conceptual unity, and was often the preserve of monks, who sometimes specialized in certain fields. Nilammahara was distinguished for mental disorders, and dispensed apparently efficacious oils.

The "little traditions" were loosely fitted into the macro-categories of the Indic tradition, and we can distinguish a Great Tradition (*sanskrutiya*) and a subculture (*upa sanskrutiya*). Dr. John Davy (1821) marvelled at the fitting of a multitude of diseases to three humours (wind, bile and phlegm), mentioned in the book under review (p. 12). But this uneasy meshing of macro- and micro-categories was common in many other spheres of Sinhala culture. (e.g. the Sanskritic four-fold caste differentiation into royal, priestly, farmer and serf, atrophied into two major caste divisions -- the farmer aristocracy, the "good people" (*honda minissu*) comprising the bulk of the Sinhala population, and the rest, collectively designated *adu* or low.)

Be that as it may, the concept of "humours" was basic to the ayurvedic medical system, and had its parallel in Ancient Greece, in Mediaeval European alchemy, too often misunderstood, and the Indic tradition. In the Tantric categorization five elemental states of matter correspond to the humours. According to Rawson on *Tantra* (1973), "the solid is symbolized by earth; the liquid by water; the incandescent by fire; the gaseous by air; while the ethereal has no direct symbol". This basis of the art of healing, in combination with the occult, tallied with the idiom of the villager. Sypernatural agents can "cause" the upsetting of the bodily humours and result in sickness. Hence, if a patient is found to be possessed by a demon, apart from exorcising the offending spirit from his body,

the pantopragmatic healer-astrologer-magician (who, ideally, had to have certain physical characteristics, such as being hairy-chested) administers medicine to restore the body to its homeostatic condition.[3] Monks who were versed in Sanskrit acquired considerable medical knowledge, and despite periodical royal edicts prohibiting indulgence of the clergy in the "despised sciences" of astrology, divining, charms and magic, in practice materia nedica was inextricably connected with the occult. The practitioner had to be, *inter alia*, a physiognomist divining the patient's illness from his facial expression, or that of the messenger sent to summon the healer, who must also have astrological expertise, be able to interpret dreams and omens, and to fabricate amulets and talismans, qualities possessed by physicians of fourteenth century England, as described by Chaucer in his *Canterbury Tales*. The doctor who joined the travellers was a "perfect practising physician"

> "No one alive could talk as well as he did
> On points of medicine and of surgery,
> For being grounded in astronomy,
> He watched his patient's favourable star
> And, by his Natural Magic, knew what are
> The lucky hours and planetary degrees
> For making charms and magic effigies,
> The cause of every malady you'd get
> He knew, and whether dry, cold, moist or hot;
> He knew their seat, their humour and condition."[4]

Here we find an acceptance of the concept of "humours" as well as a parallel of the persisting Sinhala binary categories of "hot" and "cold" foods, not temperature-wise or in terms of spiciness, but "heaty" in the ritual sense.

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3. Gananath Obeysekera. "The Impact of Ayurvedic Ideas on the Culture and the Individual in Sri Lanka", in *Asian Medical Systems. A Comparative Study*. ed. Charles Leslie. University of California Press (1976).

4. Chaucer's *Canterbury Tales*. Translated into modern English by Nevill Goghill. London. Penguin (1951).

The indigenous medical system was not interfered with by the Portuguese and the Dutch in the three centuries they administered the litt oral, for which Dr. Uragoda gives cogent reasons, apart from the fact that their sovereignty never extended to the interior and was tenuous even in the coastal belt under their jurisdiction -- the Portuguese gained anything like effective control only in the later 16th century, some eight decades after their arrival. In the first place western medicine was not demonstrably superior to the indigenous, though claiming to be based on reason rather than fancy, which governed indigenous medicine in particular, and science in general which had not, according to Dr. John Davy, "advanced beyond the darkest days of the Middle Ages". Secondly, the efficacy of some local herbal remedies was not to be gainsaid, as many of them are today -- bitter gourd for diabetes, *venival gata* as an antidote for tetanus etc. Thirdly, the Portuguese and the Dutch were not interested in going to the expense of financing an alien system of medicine to cater to the indigenous population. Finally, the Sinhala kings, especially in the Kandyan kingdom of the interior patronized traditional medicine.

Undoubtedly the health care of the people had been neglected since the 13th century, when a strong political centre ceased to exist. But prior to that the ayurvedic system flourished, when the king had jurisdiction over the whole country, and concomitantly the financial resources to provide health care for the people even in the rural periphery (at the zenith of the Dry Zone kingdoms, gold coins were in circulation, but wars and conspicuous construction of religious and public edifices depleted the State coffers, and the coinage had to be debased). The chronicles refer to hospitals in the heyday of the hydraulic societies of the Dry Zone. Dutta Gamani, who reigned 161 years before the Christian Era, has been credited with 18 hospitals, while Buddhadasa (AC 341) is said to have appointed a royal physician for every ten villages, besides hospitals for cripples and the dumb, and even vetenarary clinics. After the third century B.C. monks became proficient in medicine. These institutions and professional cadres of antiquity suffered eclipse, and all that was left in the Great City in the last century was the *bet ge*

or House of Medicine which brought together leading practitioners, among them there being those versed in the classical Sanskrit treatises. It would appear that this establishment catered primarily to the royal family, although physicians associated with it may have been allowed private practice, ministering to the chiefs and commoners.

In the peripheral rural areas, however, recourse to the professional physician was rare, for the simple reason that a skilled practitioner would not have had an adequate clientele if he was confined to a sparsely populated rural area, although there was oral communication of the location of centres of medical expertise, as in the case of the Gampaha school today. In the mid-seventeenth century, however, the institutionalised services which existed in antiquity, including hospitals, were conspicuous by their absence. The monetized economies of the past were no more, and barter was the predominant mode of economic exchange. The "fee" of the *vederala* comprised some coins placed in a bundle of forty betel leaves. In view of a non-monetized economy (even taxes were often collected in kind) state financing of medical institutions to reach the rural periphery was precluded. Consequently, everyone was physician to himself. The remedies for common ailment (agues, fevers, dysentry, aches and pains) being widely known they were cured by self-medication. Medicines were supplemented by magic, charms, incantations etc. Despite the paucity of professional doctors, contemporary observers surmised that the average man was healthy and lived to a great age, often to fourscore years, and, according to Knox, was hale even at that age. The vulnerable groups were pregnant mothers and infants in the 0-5 age group, the death rate of the latter in the first twelve months being specially high. The risk of death of mothers at child-birth (there were no professional midwives, despite reference in the literature to *vin-ambu* "but the neighbouring good women come in and do that office") was so high that extraordinary consideration was paid to the cravings of

women in that state.[5]

When the British annexed the interior of Ceylon in 1815, there was no organisation of health services outside the hill capital. Western medical services were primarily designed in the littoral for the armed services. As in India, the military establishment was responsible for health care, catering to the British civil and military service, the expatriate mercantile and planting community, besides providing rudimentary training for native vaccinators and medical sub-assistants. At a higher level, a cadre of practitioners was trained at state expense in Calcutta in the latter half of the last century, prior to which the Governor, Viscount Torrington, claimed that financial constraints precluded the establishment of a local medical school. The mass of the rural population had no access to western medicine, and even a century ago self-medication, including resort to incantations and magic, was the rule.

Although the leading western doctors idealized the state of the art in England, the number of qualified physicians was so small that only the upper classes could benefit from their expertise, and quacks of all sorts, druggists, and later apothecaries, ministered to the population at large. The structure of the medical profession ranged from the uncunning licensed practitioners to the cunning quacks, the institutions (hospitals, colleges and associations) reflecting a pyramidal class structure, supporting an inarticulate eugenic philosophy. Good health, fecundity and longevity were prerogatives of the upper classes, the affluent, who had access to the most advanced health care of the time. The life of the indigent masses depicted in nineteenth century accounts of the London poor by reformers like Christopher Mayhew, was nasty, brutish, gregarious and short, their housing insanitary crowded and delapidated slums being conducive to infectious diseases. In Ceylon the redeeming

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5. An ingenious interpretation linking pregnancy cravings to Freudian concepts such as penis-envy has been proposed in a prize-winning essay by Gananath Obeysekera. His penetrating analysis revealed (contd.)

feature of the medicines [illegible] by the folk healer, whom British doctors looked upon with disdain, was that the effect of indigenous medicine was not very mischievous, and probably did more good than harm.[6]

Although eminent army doctors such as Kinnis, Davy and Henry Marshall serving in Ceylon, reflected the Enlightenment notion that reason and science would dispel the superstition and unreason of the Dark Ages embodied in the indigenous medical system, they represented only a minute segment of the British intelligentsia. Prominent among them was John Davy, M.D., F.R.S., whose background can be gleaned from his biography of his distinguished brother, Sri Humphrey Davy (1778-1829), a chemist, inventor of the safety lamp, lecturer at University College, Dublin, from where he obtained the Ll.D., baronet in 1818, and two years later, at the age of 42, President of the Royal Society, of which Dr. John Davy was Fellow. Accredited physicians ranked high in British society by general repute and the company they kept, and they were at great pains to guard their social position. Adam Smith, in his *The Wealth of Nations* (1776) considered that confidence could not be safely reposed in attorneys and doctors, if they were of a "very mean or low condition". Their remuneration must be commensurate with the rank in society that so important a trust requires. Hence the physician maintained a social distance viv-a-vis practitioners in other inferior branches of medicine, notably surgeons, dentists, apothecaries, and druggists, which necessarily restricted their clientele. They usually completed an arts degree in one of the ancient universities, taking holy orders prior to graduating in medicine and obtaining a licence to practice from the university.

The development of medical science in England had its

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that the shape of the vegetables craved for pointed to the sub-conscious prevalence of penis-envy. "Pregnancy Cravings ([illegible]) in Relation to Social Structure and Personality in a Sinhalese Village" *American Anthropologist*. 65/ii. (1961).

6. John Davy. *An Account of the Interior of Ceylon*. London (1821)

own problems and imperfections. The Charter of the Royal College of Physicians (1518) was granted by Henry VIII "partly imitating the example of well governed cities in Italy" where medical progress was far in advance of English cities. By the end of the 15th century, however, the Renaissance had a profound impact on medical studies. Those proceeding to the continent were schooled in Greek medical literature, and the most eminent of them, Linacre, passed an arts course, became fellow of All Souls, Oxford, after which he went to Padua to take the degree of Doctor of Medicine, receiving the Oxford degree in medicine after his return.

A sartorial and behavioural refinement was expected of physicians from the inception of the profession in England. According to the original charter of the Royal College of Physicians, those permitted to practise physic should be "only those persons that be profound, sad and discreet, groundedly learned, and deeply studied in physic". While material affluence through the practice of their profession was not denied them, greed for pecuniary gain, or the making of money as their paramount objective, was discountenanced. The famous physicians of the eighteenth century were men of fashion who made large fortunes and came to be considered an elite. Their class position was not always above suspicion, however, and in one of Thackeray's novels a reference to a physician states: "I dine at Firmin's house, who has married into a good family, though he is only a doctor".[7] The Establishment insisted that "morals and manners" could only be imbibed at the universities, where potential physicians were educated alongside the gentry, and thereby acquired a tone of feeling supposedly beneficial to a vocation which had barely established itself as a learned profession, elevated above the surgeons, dentists, apothecaries and druggists. Consequently the physicians lorded it over these ancillary professions, and their permission was necessary for the performance of operations by the lowly surgeons.[8]

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7. *The Adventures of Philip.* W.M. Thackeray OUP The Oxford Thackeray cited by Saunders & Wilson (see n.8)

8. For data on the history of the professions in (contd.)

The surgeons (chirugons) along with the barbers constituted a guild. Being neither university graduates nor ecclesiastics, their status was enhanced only by the progress of the art at the hands of the great pioneers such as John Hunter (1728-1793). In 1778 Sir Carsar Hawkins was knighted for his professional services, but it was only in 1800 that the barber-surgeons came to be finally differentiated, and a charter granted to the Royal College of Surgeons. The exclusiveness and hauteur of the accredited physicians left a void in the delivery of health care in England, which was assiduously filled by the apothecaries. It may be noted that Jenner, the inventór of vaccination, which was introduced to Ceylon with great success, was an apothecary who entered the ranks of the physicians by purchasing a diploma.

It will be seen that just as the social structure of England determined the framework of the medical profession, the pattern was replicated in colonies like Ceylon. The clientele of the genteel physician was drawn from the upper and middle strata of colonial society. "Merchants" and planters constituted an entrepreneurial class, were oftentimes progeny of the English gentry, were in many cases volunteer officers in the armed forces and a cut above the "trader" or shop assistant, who served behind the counter of commercial establishments, not to mention sundry occupations such as tailors and cutters, and "writers" or clerks, recruited before the introduction of the typewriter in the present century. The native elite was still without access to western health care, but that gap was filled by medical sub-assistants, invariably Burghers, trained in Calcutta at state expense. The doctors summoned to treat the father of James de Alwis, resorted to blood letting by opening a vein or applying leeches. The names mentioned are Firmer, Zylwa and Prins, all

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England, the seminal source is A.M. Carr Saunders & P.A. Wilson. *The Professions*. London (1933). For later developments cf. T.H. Marshall, "The Recent History of Professionalism in relation to Social Structure and Social Policy" in his *Citizenship and Social Class* Clarenden Press Cambridge (1963).

Burghers. As late as 1890 there was vacillation in the choice between western and indigenous treatment. When the well-known philanthropist C.H. de Soysa was afflicted by rabies, his son-in-law, a western qualified doctor, originally dressed the wound. It was suggested that the patient be taken to Paris for treatment at the Pasteur Institute, but in the opinion of the eleven ayurvedic physicians in attendance, such a long journey was not advisable. Although western medicine was at hand, he opted for ayurveda, which failed to cure him, and he died at the early age of fifty four. Interestingly, he discussed the establishment of a Pasteur Institute in Colombo shortly before his death.[9]

A number of sociological factors contributed to a resistance to western medicine, at least to an ambiguous stance in relation to a logico-experimental science, an ambiguity underlined by Pareto in his celebrated treatise on sociology. In remote rural areas, villagers fled to the jungles on sight of a vaccinator. Even on the part of the emerging westernized elite, whose acculturation was partial, there was a curious ambivalence in respect of indigenous medicine, even early in the present century. There was a compulsion to advocate the superiority of traditional culture, transcending the bounds of reason. Ananda Coomaraswamy, a qualified geologist, was most ingenious in defending everything traditional, including the western "bugbears" of caste, literacy, democracy and egalitarianism. Perhaps his own biculturality, as son of a Tamil father and English mother, led him to extreme positions. The very class that provided the catchment area for western medical personnel defended *ayurveda* on the grounds of its antiquity and popular base. In 1947 an official Commission claimed that seventy per cent of the population patronized *ayurveda*. How this figure was reached is obscure, and the fact of penetration of many western notions and drugs into the indigenous system, presents conceptual difficulties of classification. But this figure was repeated without empirical evidence in subsequent official inquiries, including the Report of the Kandyan Peasantry Commission (1951), and the

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9. *The de Soysa Saga.* Colombo (1986).

W.H.O. Health Manpower Study of 1975.[10] The 1947 Sessional Paper argued that, having stood the test of time, despite official neglect, the system "must have something good in it". In the outcome, the efficacious remedies, alongside the ministrations of illiterate quacks, tended to be lumped together as part of a unified "system", rather than concede that, like the curate's egg, it was "good in parts". The present reviewer finds the arguments of antiquity and popularity totally unconvincing. Antiquity is no guarantee of validity, as in the case of astrology, demonology and witchcraft, even if many western qualified medical practitioners believe in the occult.

The partiality for *ayurveda* is partly attributable to the limited education of the pioneer western medical auxiliaries, trained by army doctors and in the American Mission Hospital in Jaffna. The *ad hoc* training did not attract candidates from the higher social ranks. It was officially reported that thirty five medical sub-assistants, divided into three grades, were paid 150, 110, and 90 pounds sterling per annum, circa 1840, "certainly not a very tempting remuneration to any but a native, considering the hardships and risks they undergo". These locally trained cadres were consequently reported to have been of the "lowest and worst description", inefficient, and paid less than clerks. In fact, they preferred clerical employment, there being very few new medical recruits at a time when the demand for native medical officers was steadily increasing, especially in view of the recurrent epidemics of small-pox, yaws (*parangi*), cholera and malaria. The condition of doctors worsened during the Great Depression of the 1930's. Recruitment to the government health department was practically halted, and there were many unemployed licentiates whose names were added to a lengthening "waiting list" maintained by the state health service. Relief came with the supervening malaria epidemic. Private doctors had more patients than ever before, and Field Medical Officers were recruited by the Department of Medical and Sanitary services from its handy "waiting list", for a monthly salary of Rs. 150/-, which was sufficient for a living in the inter-war years, even to maintain a motor car and an ill-paid domestic servant.

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10. L.A. Simeonov et al. *Better Health for Sri Lanka*. New Delhi. W.H.O. (1975).

The pace of westernization was retarded by the fact that the native elite had barely been weaned from traditional values. There was a noticeable change with the emergence of a cadre of doctors drawn from the middle class, usually Christian by faith, and in the beginning, Burgher by descent. For the natives, traditional conceptions of purity and pollution made contact with death and disease, especially the handling of corpses, strictly taboo. Hence the ignorance of anatomy in the indigenous system. In contrast wax skeletons were imported for instruction at the Medical College over a century ago. Traditionally even dissection of animals was abhorred, the handling of carcases of cattle etc. being consigned to the outcaste *rodi*. The traditional healer oftentimes did not even see his patients, especially in the case of royalty. He dispensed medicines on the basis of symptoms communicated to him. To undertake the dissection of corpses would have been unthinkable in the context of indigenous values. Death involved ritual pollution (*killa*) and contaminated the kith and kin in attendance. Vocational concern with the dead involved relegation to outcaste status. Even the inevitable case of death in the family involved ostracism until the pollution was erased by purificatory rites. Medical practitioners, functionaries in shrines dedicated to the gods (*kapuralas*), exorcists and others were debarred from performing sacred rites for a purificatory period of three months. The belief that his spirit returned to the abode of the deceased was responsible for the custom of removing the corpse, not from the front door, but through a hole made in the wall, which was immediately replastered after the remains were removed, to prevent the spirit returning the way the body left.[11]

In the circumstance few Hindus or Buddhists embarked on careers in western medicine. It was the marginal groups, especially Christians, who were the early medical students, even after the founding of the Medical College in 1870. Prior to this there was a motley array of western practioners trained in India, prominent among them being the Goanese P.M. Lisbao Pinto who qualified in Bombay, (Goans were among the first to avail themselves of medical training provided in Madras and Bombay) Nurtured in western radical thought, he

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11. Reported in *The Taprobanian*, ed. Hugh Nevill. (1887).

pioneered the trade union movement. These men were uninhibited by traditional values, championed as a package by the founding fathers of the National Reform League, whose nativist agenda include the revival of indigenous medicine.

It was the low castes of the traditional caste hierarchy who readily accepted liberating western values and vocations, especially those associated with money and trade, the bureaucracy and the professions. Prominent were the *karava*, ranked low, because of their ascribed occupation. In the words of the 17th century Sinhala chronicle, *Janavamsa*, "engaged in fishing, they were sinning". It has been suggested that the fishing industry was a stepping stone to trade, an occupation greatly despised in the traditional scale of values.[12] As the nineteenth century wore on, a large number, two or three generations removed from the sea, graduated to the sub-professions and professions, including medicine. With the migrant trader penetrating into the interior, their professional clansmen followed, setting up "dispensaries" in provincial towns, degenerating to the level of commercial drug peddlers. The very circumstance leading to the disesteem of the apothecary, druggist and pharmacist in England, did not deter them in Ceylon. In England, "unlike the physicians and surgeons, the apothecary charged for the drugs he supplied and not for the services which he rendered, and this led to his becoming associated in the mind of the public with the trader".[13] The contempt for trade was much greater in Ceylon.

In time a more sophisticated medical elite emerged, cultivating interests and tastes unknown to the fraternity in the previous century. Many entered the political arena, beginning with Sri Marcus Fernando, who was unofficial member of the Legislative Council. The mere fact of having to go abroad for "British qualifications", a prerequisite for promotion in the medical service, left the average doctor too preoccupied with securing a minimal qualification, usually the so-called london "conjoint" (MRCS, LRCP), to imbibe western cultural values. The cultural level of the

12. cf. W.M. Roberts. *Class Conflict and Elite Formation. The Rise of the Karava Elite in Sri Lanka. 1500-1931.* Cambridge University Press (1982), p. 282.

13. Carr Saunders & Wilson, *op.cit.*

philistine rarely went beyond the music hall and ball-room dancing, and he took readily to nativist politics on his return. Perhaps for this reason, the prestige of the profession was not high, and many preferred to describe themselves as landed proprietors rather than medical practitioners. There were, however, outstanding personalities who constituted an avant garde elite. R.L. Spittel was known as an authority on jungle lore by his novels on the Vaddas. Andreas Nell gained repute as an antiquarian. Lucien de Zylwa, though hailing from humble origins in the plantation sector, qualified at University College London, was a novelist and amateur singer (he makes much of his rendering of the popular ballad, "I'll sing thee songs of Araby", and his prowess as an after-dinner speaker). He did not suffer the bicultural agonies of his more distinguished and sensitive contemporary Ananda Coomaraswamy. In his prime he employed eleven servants in his luxurious mansion in Cinnamon Gardens, Colombo. Two GP's of Negombo, known to the reviewer, were active in the inter-war years -- Dr. James de S. Wijeyratne, novelist, composer, singer and musicologist, and Dr. C.A.A. de Silva, learned Pali scholar, author of a book on the Four Noble Truths and a devout Buddhist *upasaka* in his declining years, may be mentioned at random. Neither of them transcended their caste affiliations, nor did others. In more recent politics was the gynaecologist, Sir Nicholas Attygalle, President of the post-independence second chamber, and the eminent surgeon Prof. M.V.P. Pieris, ambassador to Moscow. Dr. S.A. Wickremasinghe, a Communist Party M.P., practised in the deep south, perhaps as an avocation. The contributions to anthropology by Dr. Byron Josef, who wrote to journals such as *Folklore* and *Man*, are little known. It would be invidious to single out contemporary heirs to the liberal tradition, including the author of the book under review (currently President of the Ceylon Branch of the Royal Asiatic Society), but our discussion will not be complete without reference to the pharmacologist, Dr. Senaka Bibile, respected for his labours in organizing the Formulary Committee and State Pharmaceuticals Corporation, invited to serve W.H.O. at the time of his death. His abiding interest in the widely separate spheres of music and politics was rare indeed. Such avocations were not merely indicators of

westernization. They promoted what Norbert Elias calls the civilizing process, which English physicians attained by prior studies at the ancient universities, repositories of the "high culture" associated with the gentry.

Whether westernization in colonial Ceylon was skin-deep, confined to the "borrowed plumes" of western dress condemned by Ananda Coomaraswamy, who adopted a unique attire, remains to be explored. Suffice it to say that Dr. Thomas Garvin's impeccable western dress and deportment were much admired by members of the exclusive Orient Club, which the Aberdeen qualified physician frequented in the inter-war years. At another level, to attend the annual Medical dance gave supreme bliss to the whisky-drinking philistine, who joined the *baila* dancers with uninhibitedly lewd postures, bawling the lyrics with gusto. ("What about the action of the tincture O.P.I"?)

The recent development of medical science in Sri Lanka owed much to the incorporation of the Medical College as a Faculty of the University of Ceylon in 1942. The author deals with the minimal specialization early in the present century. Even gynaecology was not recognised as a speciality. The need for an Association of Medical Specialists became evident. The university made provision for a large number of new fields of instruction and research, which came to be represented on its medical faculty by full-time professors assigned beds in the major teaching hospitals now under a separate Ministry. Increasing commitment to medical science also gave rise to professionalims, but as elsewhere we have to separate the sheep from the goats. As against the elite of specialists, untroubled by financial worries (except the over-riding one of evading taxation), given to a conspicuous consumption bordering on vulgarity, were the aggressive and impecunious mass of GP's, those in the state sector agitating from the outset for better salaries through unionized professional associations, notably the Government Medical Officer's Association (GMOA), founded in 1924, which progressively grew in strength.[14] It was in a position to para-

14. In the present regire of "channelled practice" allowed to government doctors after working hours (8-12 noon; 3-5 p.m.) the reviewer found that non-specialists (contd.)

lyse the health care system of the whole country by strike action, a weapon unthinkable in the professional milieu of the past. The effectiveness of its current deployment to exert pressure on the government has made it an important institution in recent social history.

With the eclipse of the family doctor owing to the emergence of a new, technologically-oriented profession using high precision and expensive equipment far in advance of the X-ray technology in charge of radiologists, and the modest pathological laboratories attached to hospitals even after World War II -- laser, sonic and scanning diagnostic aids, requiring the services of high calibre graduate technicians -- besides revolutionizing the role of the specialist physician and surgeon, left the GP bereft of his traditional clientele. The latter, assumed by specialists to be something of a mediocrity and a private entrepreneur to boot,[15] found his functions stripped down to counselling and referral services. The prescription, hall-mark of a doctor in the popular mind assumed insignificant dimensions owing to the marketing of drugs by multinational commercial laborataries, and their often illegal peddling by unlicensed drug peddlers.

If a major objective of the GMOA is the betterment of its members above the "very mean and low condition" to which the rank and file of licentiates was repeatedly approximating in the recent past, it was in accord with Adam Smith's notion that adequate remuneration was a *sine qua non* for the trust and confidence that patients, rightly or wrongly, reposed in medical professionals to whose judgment and care they entrusted their very lives, and to whom oftentimes they collectively transferred fortunes by way of fees. Even if not always realised in practice owing to dominant pecuniary motives - commercialization is the bane of professionalism -- ideally, the doctor should not work in order to be paid. Rather, he should be paid in

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supplemented their incomes by working shifts as resident physicians in private hospitals, earning as much as Rs. 8000 per month.

15. cf. R.H. Titmuss *Essays on the Welfare State* London (1963) p. 178-179.

order that he could work and be trusted to give what he cannot be compelled or contractually bound to give.[16] If he is, his strategic reaction is to "work to rule" Herein lies the real bargaining power of the GMOA and other medical and para-medical unions. In the last resort, the professions generally, and the medical profession in particular, should be judged in terms of their compatibility with the good life,[17] which is the aim of the civilizing process.

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16. T.H. Marshall, *op.cit.*

17. *ibid.*