DISCUSSION

Care before the Primary

RANDALL SEQUEIRA

Abstract

Primary care with indigenous communities, just as with any other community, needs compassionate perseverance in individual cases but also touches on a communitarian value- system that can truly give insights into the community's self-determined idea of health and wellbeing. It would also need a compassionate exploration of a community's history and positioning of an individual-household contextual situation in the present-day political economy that values the individual over a more eco-centric idea of community. This commentary explores the contextual ideas and possibilities to take into account before a compassionate and technically sound primary care intervention within a continuum of care.

Keywords: *primary care practitioner, Adivasis, indigenous community, community health; diabetes.*

Laxmi's story, mentioned in a recently published case study in the *IJME* [1], left a deep impact on me. I felt a profound sense of professional solidarity, especially towards the team at the Purna clinic working in the Dangs. I have had similar experiences in the past, having worked in Thuamul Rampur block with the Kondh Adivasi or indigenous community in Kalahandi, Odisha. The sense of helplessness that washes over you and revisits you in times of leisure and rest, particular as a primary care practitioner, trying to do their best in a resource and access-constrained situation, is at times overwhelming. How much of the scarce resources can you devote to a complex problem like Laxmi's, when your Trust has budgetary constraints and your mind has human restrictions? To survive professionally, we have learned techniques of "moving-on" and give in to the utilitarian urge of what we consider the greatest good of the many, while working in a setting that intersects primary healthcare and community health. Sometimes, it is just the simple principles of triage that win, and I have seen this in my practice as well.

Shyam, a co-author of the case study [1], has, at various times, discussed with me the diagnoses and follow-up related aspects of patients he and Apexa have come across at Purna, and reading Laxmi's story painted a vivid picture of the perspective of medical practitioners. I realised, however, that although Laxmi was a tribal girl, I had no idea about her surname or to which Kabila she belonged. The Dangs have people belonging to the Bhil, Kunbi, Warli, Kolcha and Kathodi communities, as well as a particularly vulnerable tribal group called the Kotwalias. It has a unique history of being a tribal princely state ruled by a federation of kings, still acknowledged by the Government of India. People in the area speak the Dangi dialect, along with Gujarati. If Laxmi had come in from neighbouring Nandurbar in Maharashtra she might have been Pawri or Marathi-speaking. Her linguistic and indigenous identity is important due to the different perceptions and pathways of livelihoods, relations with the surrounding ecology and communities, and deterministic ways of thinking and practising culture.

The mistrust of the government and the privately provided healthcare services, due to cultural perceptions of alien environments in these clinics or spaces, is well documented. A further exploration of why tribal communities are so mistrustful of "outsiders", non-locals, plains people, settled cultivators, or townsfolk (including doctors who might themselves be tribal) might reveal a deeply unsettling colonial history of the community. The illegal declaration of parts of Dangs forests as "reserved" by the British government, and the continuation of similar repressive policies by a colonising Indian government post-independence, has led to numerous struggles of resistance and assertion of a cultural identity entwined with the local ecology by the indigenous adivasi-moolnivasis. For a community that has had this kind of history — disenfranchised from the forest of their Gods and their livelihoods — a marginal existence becomes the only way to survive. Such a household might be sunken in alcoholism, which could lead to domestic violence. While I am not justifying the behaviour of Laxmi's father or family members, the context of the political economy of the larger community and how it impacts the individual household need to be understood to recognise the limits of a primary care practice. This understanding will hopefully reduce the emotional turmoil for the practitioner.

Type 1 Diabetes is a very complex disease to treat, even in town-based settings, considering it usually begins during childhood and adolescence — a time when an individual cannot take full responsibility for their own health; or is at times too impulsive to take their health seriously. However, tribal communities have a deep faith in a number of herbal medicines that they believe come from their own forests, to which they may be more compliant. An exploration of simple preparations with mild anti-diabetic/anti-oxidant properties like mango leaves, jamun kernels, or bitter gourd/neem extracts based on what might have been locally available yet not harmful, is possible. The use, discussion on harvest, demonstration or administration of a herbal preparation can be used as a way to "win over" an Adivasi patient, in the process making them take their complex disease seriously. It also opens a window into demystifying a disease, starting from a taste-based paradigm of how "bitter might cut the sugar" of diabetes. Appointing an Accredited Social Health

Activist (ASHA) from the Adivasi community, or from the patient's *pada*/toli/hamlet, is also of great potential help to the community-based rehab team, although they too are now overburdened with a lot of work.

The average stay of Adivasi patients in big hospitals with linoleums smelling of sanitiser, white-coated people in charge, and food that is alien, is usually just for 24–48 hrs. They would find a way back to the soothing lap of their home in the forest as soon as humanly possible. An escort who works as a hospital navigator is someone who could help extend their stay by a day or more if they are Adivasi, and I believe Shyam and his team have tried this too, but to no avail. All said and done, reading of Laxmi's case, along with the discussion on ethical dilemmas has helped to jog my memory about some of the most difficult patients I had to work with to get them admitted and to stay admitted in an environment I did not have any control over, which at multiple times appears colonising and disrespectful to Adivasi people.

A framework to discuss Laxmi's story that looks beyond the principles of beneficence, nonmaleficence and justice, from a "mainstream" or "medical bioethical" lens, against a background of epistemic violence and historical injustice perpetrated on indigenous communities, might help practitioners. Advocating for "bio-cultural safety and sensitivity" protocols might also help in improving the health seeking behaviour and compliance with treatment of tribal patients.

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DISCUSSION

A qualia-centric approach to Ayurveda and Hindu knowledge systems can address modern science's blind spot

ANAND VENKATRAMAN

Abstract

In this paper, I argue for approaching Ayurveda and Hindu knowledge systems in a qualia-centric manner, the way their originators intended. The materialist assumptions that underlie modern medicine, while undeniably effective, are not the only way to understand the body, just as the Western tonal system is not the only way to approach music. Using the wrong metaphysical lens is the root cause behind many seemingly intractable debates on the validity of Hindu knowledge systems. At the same time, it is important to have externally verifiable benchmarks — quality, reliability and efficacy — as universal metrics, and every healthcare provider must seek to meet them.

Keyword: *Ayurveda, Hindu Knowledge Systems, qualia-centric*

Introduction

Contemporary academic discussions on Ayurveda, as in the recent issues of this journal [1–3], distinguish "logical" parts of Ayurveda from their "magical" precursors in the Atharva Veda, and a parallel "magico-religious" stream involving tantra and mantra. I believe this is driven by an incomplete understanding of the unified intellectual foundation of Hindu civilisation. Instead of treating them as just a poor man's version of European science — whose value exists to the extent that parallels can be found in Western journals — we must approach them the way the Hindu originally approached them — by being qualia-centric.

Qualia are the "introspectively accessible, phenomenal aspects of our mental lives" [4] which cannot be communicated through language. For example, the redness of a rose cannot be expressed to your friend in words; at best, you can liken it to other red items, but the experience of redness is a private, subjective phenomenon. A qualia-centric approach will prize the first-person subjective experience as fundamental, instead of trying to explain it away through verbal sleights of hand. Such an approach — by integrating insights from consciousness research and neuroscience — will help resolve previously intractable problems created by the encounter between Western modernity and Hindu knowledge systems.

Why qualia-centricity?

The reason for choosing this particular approach lies in the