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Barber-Surgeons

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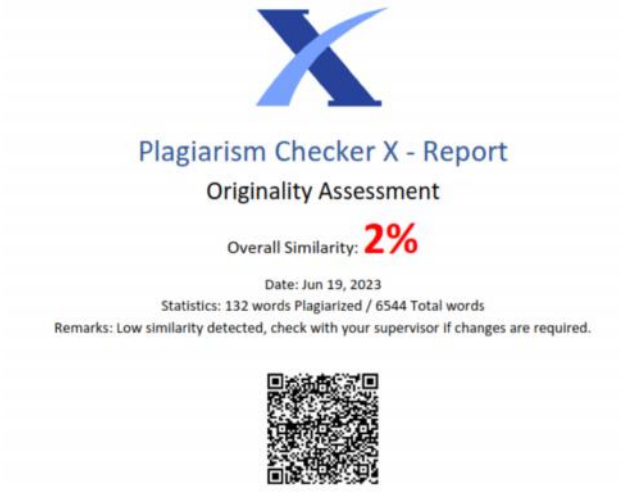

ABSTRACT

The Nai, Nais, Sain/Sen, Sain-Thakur, Savita-Samaj, and Mangala - Barber occupational castes. The name is thought to be derived from the Sanskrit word napita. They can be found across India. They used to work as barbers in the past. Additionally, the barber has various significant responsibilities connected to weddings and other festivals. They assist the Brahmin and serve as the marital priest for the lower classes who cannot employ a Brahmin. Due to their prominent role in wedding ceremonies, has developed a reputation as matchmakers among all respectable castes. They acted as surgeons since Baid/Vaid (doctors), most of whom were Brahmins, did not practise it. Barbers frequently performed as musicians throughout southern India, and various other castes in Malabar hired barbers as purohits during funeral ceremonies. Barbers serve as village physicians, cleaning the ears of their customers and unobtrusively trimming their nails while maintaining their professionalism. Blooding and cupping his patients are among the treatments he uses, leeches, tooth extraction, and the lancing of blisters. Whenever he performs this activity, he adopts the role of a barber-surgeon in the Middle Ages. The Nai community's members have now abandoned traditional occupations in favour of more contemporary ones. In the Puranas, they are called Ampitta. The term 'Ampitta' derives from the Sanskrit term "Ambistha". Ambistha has been corrupted into Ampitta. Ambistha is derived from the Sanskrit word for Physician. They were also physicians in the earlier days. They could readily perform both professions as they moved from house to house. They were also known as Ambashtha due to their physic practice. Historically, they have been associated with Indian

medicine and the physician profession. In the Colonial period, due to the advent of allopathic medicine, the promotion of education, and the fashion of cutting hair, these doctors were divided into educated and uneducated doctors. Over time, these uneducated doctors came to be called "barber-surgeons".

KEY WORDS

Brahmin, Sanskrit, Nai, Baid/Vaid, Puranas, Doctors, Barbers.

INTRODUCTION

The information collected from census and economic data in North Indian villages described that the few families of village barbers seemed to produce a disproportionate number of medical technicians and curers. Was it only a peculiarity of a single village, or was there something about the trade of barber that had an analogue in aspects of medical practice and eased the passage from barber to paramedic.

The possibility of a connection between Nai barber and modern medical practitioners in the decades immediately after the independence of India recalls *mutatis mutandis*, the connection between the guild barbers and the practice of surgery in medieval Europe. Has a counterpart in early Ayurvedic medicine when surgery was also a speciality separate from the rest of medicine.

The parallelism that early surgery, both in India and Europe, was treated as a speciality separate from medicine has a historical explanation. In both regions, early surgery grew out of the need to treat wounds suffered in warfare and, jousting in Europe. However, the connection of barbery to surgery and medicine, which also has an historical component as do all social phenomena, is in addition based on "social grooming" behaviour which is not only pan-human but also is found among the non-human primates and other animals. It was a relatively small step in early times, when medical knowledge and technology were limited, from cutting hair and nails to treating visible external pathology such as sores and boils. As the young barber Chandru explains in Anand's charming story, *The Barber's Trade Union*. "I learnt how to treat pimples, boils, and cuts on people's bodies from my father, who learnt them from his father before him" (Anand,1959)

Barber -Surgeons of Medieval Europe

After A.D. 1100, surgery in Europe was largely in the hands of barber-surgeons. Earlier in the Middle Ages, both medicine and surgery were practised almost entirely by men of the Holy Orders, but a priest who shed blood was debarred from the higher offices of the Church and a Papal Decree ordered the clergy not to undertake any surgery. This prohibition was reinforced by the Tenth Lateran Council in 1215. Moreover, even monks began to show the contempt for manual labour that was so characteristic of medieval nobility. In any case, the barber-surgeon was firmly established at the beginning of the 12th century and continued to dominate the practice of surgery on the continent up to the 19th century.

Barber-surgeons originally worked as assistants to bathkeepers but soon became independent and powerful with the help of their well-organized guilds. The guild system enhanced their professionalism. Guilds controlled entry into the craft and established and enforced standards. Faced with little competition, European barber-surgeons and the relatively few pure surgeons had the opportunity to advance surgery and as a group to reap the benefits of improvements. As compared to medicine which suffered from dependence on classical and Arabic authority, the achievements of surgery were remarkable (Bishop, 1987). The system of masters and apprentices offered better training than the informal father-son system in India. When surgery and barbery finally were separated, surgery had become such a complex field that combining the two roles in a single practitioner made no practical sense.

That surgery grew up with barbery reflected social grooming behaviour that underlies both, the scarcity of academically trained surgeons, the relative simplicity of early surgical techniques, and a complex of attitudes

associated with blood which tended to demean surgery. Nonetheless, the need for surgery and the growing technical complexity of the craft led to more and more full-time surgeons, albeit still members of the same guild as barbers, and inevitably raised their status. So too did the fact that they dabbled in medicine for want of physicians outside major cities and their relative scarcity even in cities. The result was a union of medicine and surgery whose practitioners received their training in universities. But the process was not completed until the 19th century.

There was a strong tendency among barber-surgeons as well as physicians for their sons and sons-in-law to follow the practices of their fathers and fathers-in-law. Important features of the social structure of barber surgeons were the family and the guild. A barber-surgeon headed a family and was called Master. He took on apprentices who were limited in number by the guild except for sons and sons-in-law. Further, the Master's sons could not marry outside of the guild though daughters might, but the husbands of daughters could become apprentices to their fathers-in-law, thus affording an opportunity for the prospective son-in-law. In addition, medieval barber guilds had patron saints whose holidays were observed by its members.

Because they monopolized the craft of bleeding, which depended on astrology, they were familiar with forms of magic. Thus, the social structure provided a means of perpetuating the barber-surgeon craft in a family line as well embusing its members with special powers for healing (Ackerknecht, 1984; Libby, 1922).

Barber-surgeons had to serve an apprenticeship of three years and then were travelling journey-men for six years before becoming masters. They not only engaged in cosmetic activities and were surgeons but also treated all types of diseases. They also did obstetrical work despite the activities of midwives. Barber-surgeons were the actual doctors of the people, for no country could bear the cost of providing expensive university-trained physicians for everyone. With their high fees, physicians could not make a living in the rural areas where most people lived. Physicians served only the urban elite, thus treating far fewer clients even in the cities than did barber-surgeons. A few examples of the urban proportions of physicians to barber-surgeons bear out the importance of the latter in making medical care widely available; during the 15th century in Geneva, there were only eight physicians to 90 barber- surgeons; in Zurich as late as 1797, the ratio was four physicians to 34 barber-surgeons plus eight midwives (Ackerknecht and Fischer-Homberger,1977). Hans Sachs (1494-1576), a craftsman-poet, concisely depicts the barber-surgeon (English translation in Ackerknecht, 1984):

I am called everywhere
I can make healing salves
I can cure new wounds
Also fractures and chronic afflictions,
Syphilis, Cataract, Gangrene, pull teeth,
Shave, wash and cut hair, I also like to bleed.

At first, the social status of barber-surgeons was rather low but they rose steadily. Their background in hands-on medicine meant that they had more to offer from a practical point of view than did the theoretically inclined university-trained physicians. They were needed to serve the armies and navies of the time, incessantly engaged in warfare. They were available during plagues and to patients in hospitals, where they often lived. Their guilds, known as Barbers' Guild or Company of Barbers, were powerful and aggressively defended their prerogatives. In the 18th century, surgeons separated from barbers and became equal to physicians. The final step was the reunification of medicine and surgery: in 1794 in France; during the mid-19th century in Great Britain and Germany.

In London, the company of Barbers had two classes of members, those who engaged in barbery proper with perhaps some tooth drawing and bleeding and those who practised surgery, known as barber-surgeons. "For aught we known to the contrary, a perfect harmony and good under-standing existed between these two sections of the Company, and it is probably that the ranks of the latter were continually recruited

from the former" (Young,1890). The Company of Barbers gradually became the Barbers-Surgeons' Company as more of their members engaged in the practice of surgery. Each large city resembled London in that it had its company of barber-surgeons.

However, there was also in London another fraternity or guild that of the surgeons, more aristocratic and unconnected with the barbers. The Surgeons' Guild was not numerous, possibly never exceedingly more than 20 members. The two organizations competed for the supervision of the practice of surgery, with the barber surgeons winning control in the early 15th century. All the surgeons in London were finally united by an Act of Parliament in 1540. Moreover, the Act separated the practice of surgery from barbery, although the two callings were united under a single corporation (the United Barber-Surgeon Company) for legal purposes. The partnership lasted for two centuries.

A similar competitive situation existed in France, where quarrels between the College of St. Côme in Paris, a college of surgeons founded in 1279, and the barber surgeons continued until the 18th century when Louis XV abolished the barber surgeons, created five professorships at St. Côme, and raised the status of surgeons." After the foundation of the Academy of Surgery (1731) and the foundation of four professorships at Montpellier, (whose university was one of the greatest centres of surgical and medical instruction], the teaching of surgery in France became the best in the world till it was disorganized by the Revolution" (Parker, 1920).

Nai Barber

Crooke lists some of the functions of the Nais in north-west India in the late 19th century as shaving, haircutting, shampooing, and nail paring. These services are quite similar to the cosmetic duties of the medieval European barber; in fact, they define the role of barber. Of much greater interest is the seemingly arbitrary connection of barbery and surgery in the two widely separated areas. In pre–Independent India, as in medieval Europe, the Nai Barber took care of simple surgical procedures. "He is the rural leech, bone setter, tooth drawer and performer of petty operations, such as lancing boils and the like If a Muhammadan, he usually performs circumcision; but some Hindu Nais perform this operation for their Musalman neighbours" (Crooke, 1896).

In Europe, the barber-surgeons formed guilds. Although there was well established succession from fathers to sons and son's in-law, masters could take a limited number of apprentices from families with no connection to barbery. Entry was limited and so competition was controlled. The Indian Nai Barbers forms an endogamous caste enjoying a monopoly of a traditional occupation. Entry into the craft is by birth. Training takes place largely in a familial context. Children learn their skills and duties from their parents or other family members. Such control of the craft as is necessary to settle quarrels between barbers or between them and their clients is exercised by respected caste elders. Although castes and guilds differ in many ways, particularly concerning the purity- pollution and hierarchical aspects of caste, they resemble each other with regard to a traditional occupation, endogamy, and the training of novices. Endogamy was less strict for guild members than for castes and the master-apprentice relationship is different from the parent-child sequence for transmitting a craft. Nevertheless, when the great differences between Indian and European civilizations are considered, the parallels between castes and guilds are striking.

Barbery and the associated function of minor surgery are matched in importance by the Nais' ceremonial roles. The ceremonial duties of Nais, even in their somewhat attenuated modern form, have almost no counterpart among the medieval barber-surgeons. The Nai Barbers, men and women, have numerous and important roles to play during the ceremonies of birth and marriage that take place in the families of their clients. For example, at marriages, a Nai woman helps to bathe the bride and groom, braids the bride's hair, grinds flour, mixes dough, removes leaf plates after feasts, cleans pots, and calls villagers to ceremonies (Freed and Freed, 1976). Although they no longer help to arrange marriages, they continue to carry gifts and messages to the married daughters of their clients. Castes traditionally served by Nais could not manage without them at weddings, and they were well compensated for their services (Freed and Freed, 1976). However, their

former role in death ceremonies has been reduced. They once had such duties as shaving a corpse, helping to prepare funeral feasts, cleaning the dead man's house, and cooking food for dogs, the symbolic messengers of Yama, the God of Death (Freed and Freed,1980). As is also true for castes other than Nais, hereditary serving relationships that are demeaning, such as the foregoing, have been reduced or eliminated since Independence. Nonetheless, Nais spent and continue to spend much time in ceremonial activity.

In India, as in Europe, there was a sophisticated medical tradition in early times involving not only medical theory and practice but also surgery. Training in the most advanced medicine and surgery was the province of the educated elite and was not ordinarily available to uneducated, low caste people. However, expert physicians and surgeons were few and could not begin to treat the rural population. Therefore, Nai Barbers became one of the medical practitioners who were widely available to the common people.

Nais, Bhagats, Vaids, and Physicians Share the Medical Scene

While in Europe, barber-surgeons were the principal doctors for most of the population and were without significant competition outside the cities except in obstetrics. Nai Barbers shares medical activities in villages with a variety of other curers. Villagers use midwives, bone setters, and snakebite curers as needed and frequently consult vaids (Ayurvedic physicians) and doctors who practice Western Biomedicine.

Especially important are the bhagats, swamis, siyanas, and hakims who treat illnesses believed to be caused by supernatural beings. Many but not all villagers believed and still believe that supernatural beings, especially ghosts, can cause illness and death by seizing their victims' souls. Fever, a symptom of many illnesses, is conceived of as an index of illness brought by a ghost. Other symptoms may be difficult breathing, choking, convulsions, and other bodily movements which indicate pain and discomfort. Ghost possession has a different set of symptoms: the victim falls unconscious or into a semi-conscious state while the intrusive ghost speaks from its victim who, in a dissociative state, may run to a well or rail-road, supposedly to commit suicide. Doctors and medicine may be used for ghost illness with the idea that they will help to fight off the ghost, but exorcists are also used. Only exorcists are used for cases of ghost possession. Other major diseases, such as cholera and typhoid, may be attributed to Mother Goddesses. Greatly feared, the goddesses are appeased with ceremony and offerings in the hope that they will not cause diseases or will take them away should they appear. The great epidemics of former times no longer occur, but the relevant beliefs and ceremonies persist.

In addition to the foregoing roster of curers, the vaids, who are practitioners of India's indigenous and sophisticated medical tradition, Ayurvedic medicine, are generally within reach of many villagers. In the 1950s, vaids were not rated as highly by urbanized villagers as physicians trained in Western Biomedicine (Taylor, 1976). However, by the 1970s, attitudes changed somewhat, and the following statement was heard a number of times in the village: "Allopathic medicine (Western Biomedicine) puts down the disease, but Ayurvedic medicine roots it out." The increased prestige of Ayurvedic medicine was due to the Government programme upgrading Ayurvedic professional training and Government funding of local Ayurvedic clinics and dispensaries for villagers.

Since the 19th century, the practice of Western medicine has become prominent in India. Western medicine takes various forms: Western Biomedicine, Popular Pharmaceutical medicine, pharmacy, and Homoeopathic Medicine. Homoeopathy was introduced by the English and other European doctors in the 19th century. It appealed to an urban elite as a modern type of medicine, which did not require a great break from traditional ideas. There is some question as to what extent Indian doctors of Homoeopathy practised a standard version of this medical theory. Homoeopathic training and registration as a Homoeopathic physician were primarily through correspondence courses. Homoeopathic doctors could then use a variety of practices (Jeffery, 1988).

Western Biomedicine was introduced in the 19th century. An early event was the use of vaccinations for

smallpox in 1802 in Bombay. In Delhi, the British built hospitals, and Western medicines were dispensed in pharmaceutical shops. Although the acceptance in the rural areas of Western Biomedical theory and treatment by physicians has been slow, the adoption of the actual medicines, such as aspirin and later antibiotics, has been rapid. The concepts of germs, contagious disease, and other sources of infection are still not well understood by many villagers. They have interpreted germs in terms of their earlier knowledge of illness caused by an intrusive ghost. Injections of antibiotics reduce fever (in its supernatural aspect as an index of ghost illness) and to some extent combat the ghost. In any case, the Government sponsors Western Biomedicine in hospitals and other public health facilities in the Delhi region, especially the city, and in recent decades has extended these facilities, including primary health centres, dispensaries, clinics, and hospitals into the rural region and often directly to villages (Gazetteer Unit, 1976: Ch. XVI).

The practice of Popular Pharmaceutical Medicine, the term currently used for the dispensing of powerful Western medicines by largely untrained practitioners, is widespread. As the term suggests, Popular Pharmaceutical Medicine grew out of pharmacy. In Europe, in early times, apothecaries were allied with grocers and Spicers. During the 13th and 14th centuries, the pharmaceutical profession gradually separated from such merchants. The pharmacy became more of a medical institution. In England, apothecaries were less controlled by physicians than on the continent. In 1617, English apothecaries were given a separate charter affirming their ancient right of both prescribing and dispensing medicines. English physicians felt that pharmacists were infringing on medical prerogatives, and there was considerable competition between the two professions. In 1703, there was a judgment in favour of the apothecaries. In 1815, by an Act of Parliament, apothecaries were confirmed in their right to practice medicine but were directed to assist and cooperate with physicians and surgeons.

Practitioners of Popular Pharmaceutical Medicine in India act in the traditional double capacity of physician and vendor of medicines that characterized pharmacy in England. They obtain the drugs from pharmaceutical shops whose proprietors show them how to give injections and keep them up to date on new remedies. Taylor (1976) writes, ...we uncovered not only an underground system of health care providing the bulk of medical treatment for the people of India, but also a widely pervasive and previously unrecognized separate system of medical education. The professors are the drug-detail men from pharmaceutical companies, often the largest and most reputable companies in the world. The junior faculty are the pharmacists in the cities. Each pharmacist has a continuing class of practitioners scattered throughout the neighbouring villages."

Noteworthy differences between the current Indian and European medical scenes derive from their different histories. Western Biomedicine was an indigenous development in Europe, gradually dominating competing practices and practitioners if not entirely replacing them. Most medical care is dispensed by university trained physicians. Although Homoeopathy has its adherents and some women prefer trained midwives to doctors, there is no longer any place for surgery practised as a craft. The scope of informal folk medicine outside the medical mainstream is much reduced. (Shryock, 1969).

In India, the situation is different. Western Biomedicine was not an indigenous growth. A relatively late addition to Indian medical practice, it found four well developed and solidly established theories of disease, namely, the two scholarly medical traditions, Ayurvedic and Unani medicine based on humoral theories, and supernatural causation owing to invasive ghosts and deities. Arabs brought Unani Medicine to India and with it the popular diagnostic technique of pulsing, originally from China (Porkert, 1976), and the theory of the wandering uterus. In yet another tradition, Unani Prophetic Medicine, the Prophet Muhammad introduced the concept of disease inflicted by supernatural beings on humans as retribution for sin. The Prophetic doctrine of the cause of disease is based on retribution for sins. Thus, it is somewhat similar to the Hindu belief that one's soul's past actions cause fever and ghost illness. Both Islamic and Hindu beliefs call for the exorcism of the ghost causing these diseases.

Western Biomedicine has by no means usurped the authority of these competing systems nor has it replaced the special medical services offered by Nais, bone-setters, snake- bite curers, and midwives. Even when its remedies are proven to be effective, rural people often interpret their effectiveness in terms of indigenous belief or supplement them with traditional rituals and practices. The impersonal scientific persona of Western-style physicians and hospitals may be unsettling to rural people, which, added to the distance that a patient often must travel to receive treatment, tends to keep Western Biomedicine as a specific theory and style of treatment on the outskirts of the village (Jeffery, 1988; Marriott, 1955; Bhasin and Srivastava, 1991). However, the medicines themselves are everywhere, distributed in the rural areas by practitioners of Popular Pharmaceutical Medicine, such as two of the Nai paramedics in Shanti Nagar. Moreover, the Government has tried to achieve a synthesis of Western Biomedicine with Ayurvedic Medicine (Taylor, 1976). Kutumbiah (1969, Preface to the Second Edition: xvi) rather pejoratively comments on the new look in Ayurveda: "Ayurveda looks very venerable and dignified in her own ancient lineaments but with this "new-look" given to her she looks a flirt coquetting with modern medicine for petty favours and recognition."

The history of European barber-surgeons begins with a combination of barbery and simple surgery. In the absence of significant competition from physicians, the latter role developed to the point where surgery was such a complicated specialty and so time-consuming that barbery and surgery were separated. Surgery was then joined with medicine, and medical training took place in universities. Surgery was no longer a craft based on a guild organization, and the barber- surgeons who did not follow the medical path became simply barbers.

In India, the barber had a triple role: barber, minor surgeon, and ceremonial specialist. Although medicine and surgery were at first separate, by the second century A.D., they were combined in Ayurvedic Medicine and so barbers had lesser scope to develop their medical role. Moreover, their ceremonial duties took a great deal of time and provided considerable income factors which would reduce motivation for the elaboration of the surgical role. The Nais of Shanti Nagar had an additional source of income, namely, owning or working in barber shops in nearby Delhi, activities which strongly pushed them in the direction of barbery. The Nais who opened shops had military pensions from service as barbers, which provided initial financing and also were used to finance their children's education.

When members of castes other than barbers played a medical role, it was usually as a traditional curer who treated ghost illness and possession. There were a few exceptions. A Brahmin had training to become a physician of Western Biomedicine while in military service. He continued in-service and never practised in Shanti Nagar. Another Brahmin who was a compounder worked in a Government dispensary and also operated a pharmacy in a nearby village with a woman physician of Western Biomedicine. Villagers regularly called her a nurse because they associated the role of vaid, physician, and exorcist with men.

All village exorcists were men. Although one chuhra (sweeper) and one chamar (leather worker) were bhagats, most exorcists were Brahmins. (Mullahs, Muslims from Delhi, also were called to the village as exorcists). The Brahmins' ascribed caste status as priests, which involves connections with supernatural's and the power to influence them through the knowledge of mantras, gives village Brahmins a hereditary claim to the role of exorcist. The Atharva Veda serves as the ancient authority for this aspect of the Brahminical role. The Brahmin exorcists of the village did not appear to be particularly favoured by the villagers who were as likely to summon the sweeper or leather worker mentioned above as a Brahmin. Among the Brahmin exorcists was a man who not only drove out ghosts afflicting humans but also exorcised cattle disease in a village-wide ceremony called Akhta (Freed and Freed, 1966). Another traditional Brahmin curer treated snake-bites. He used a decoction made from plants rather than supernatural methods.

Concerning the connection of caste and medical study, there were no great restrictions in the classical texts. Kutumbiah (1969: xliv) remarks, "The science of life was to be studied by Brahmins, Kshatriyas and Vaisyas. Brahmins were to learn it for doing good to all creatures, Kshatriyas for self-preservation, and

Vaisyas for gain. Susruta asserts that some say a Sudra of good family and character may be admitted as a pupil. In general, all may study this science for the acquisition of religious merit, wealth, and pleasure." Although Nai Barbers and barber- surgeons had much in common, particularly a protected craft and endogamy, significant differences between their circumstances in India and Europe have had an effect concerning individual social mobility. Barber-surgeons were reckoned among the craftsmen. They did not form part of the emerging bourgeoisie, certainly not of the nobles. But when surgery was joined to medicine, the individual barber-surgeon who opted for surgery entered the emerging middle class. Moreover, a traditional barber-surgeon who became wealthy achieved an enhanced status. Although he himself might feel social uncertainty, his grandchildren "would not experience any uncertainty of status This point is usually put in the form of an admission that families can and do sometimes ascend in the traditional societies, but that it took a generation and more" (Laslett, 1971). We do not know how much social mobility took place in traditional European society before the Industrial Revolution, but social origins were in all probability less restrictive there than in traditional Indian society.

The major barriers to mobility in India are poverty and the caste system, the latter more from the point of view of intra-caste customs and the scarcity of caste fellows in influential positions rather than from the rank of a particular caste in the hierarchy, although all such matters are inter-connected.

Because surgery in India developed as a part of medicine whose practitioners underwent special training and generally were members of high caste families, the Nais could not ascend the social hierarchy from craftsman to educated professional by riding a rapidly developing specialty, surgery, as had some of the European barber-surgeons. If Nais wanted to pursue medicine, their traditional craft background would be of no help. They would have to develop a tradition of higher education. However, their caste per se would be of no particular hindrance, especially in modern India. Although several Nais had attended or were attending higher secondary school, none had yet gone to college, which would be a necessary step for entry into the professions. In general, the Nais practise their traditional caste specialties, protected as they are by the caste system. They seem to be at least one generation away from the professions, with little economic pressure to push them in that direction and without a tradition of education which would ease their way.

CONCLUSION

The connection of barbery and elementary surgery appears both in Europe and India. In a general sense, both are aspects of social grooming behaviour, a pan-human activity so the association is not surprising once it is noted. On the other hand, the two civilizations are sufficiently different so that the parallelism is easily overlooked, the more so as other aspects of the roles of medieval barber-surgeon and Nai Barber are different. In Europe, the separation of medicine and surgery and the relative lack of pure surgeons gave barber surgeons a major medical role. In medieval Europe, they were the doctors of the common people. The craft eventually disappeared as surgery was combined with medicine after a separation of centuries. However, those barber- surgeons who practised surgery to the exclusion of barbery were able to enter the middle class as members of a profession.

In India, surgery since ancient times has generally developed in conjunction with medicine, leaving the Nais a minor medical role which was a dead end. It could not lead into a profession because the professional medical-surgical role was already filled. Training for the role required much more education than could be provided in a familial context, the setting in which Nais learned their craft.

Majorly, the role of Nai Barber has been relatively stable, retaining barbery, ceremonial activity, and the occasional treatment of minor dermal eruptions. Individual Nai Barbers of Shanti Nagar have raised their status because their economic situation has improved owing to some salaried employment and the ownership of barber-shops in Delhi. Moreover, their employment in modern hospitals, the ability to give injections, and access to and distribution of modern medicines all confer prestige. To judge from the few cases presented by the small Nai community of Shanti Nagar, the barbers seem disproportionately drawn to careers as paramedics.

The apparent connection could be simply a matter of chance or it could reflect their old tradition of minor medical practitioner. But the Nais have not entered modern medicine except as paramedics; they seem to be a generation away from acquiring the university qualifications necessary to become doctors. Barbery remains relatively lucrative, and entry into the craft is largely governed by the caste system. There is little economic pressure to push Nais in the direction of the professions with their long and difficult years of study.

Although in India as in Europe, the connection of barbery and surgery has almost entirely disappeared, that it once existed at a time of limited knowledge and simple technology before the modern era of rapid communication strongly indicates an independent development in the two widely separated areas. It is not the simple question of a child's learning the trade of a parent. Rather it is a link between activities that in modern times seem worlds apart. Such a linkage could be fortuitous, but in all likelihood, it reflects both the use of knives against the flesh and an inevitable elaboration of social grooming to encompass the treatment of illness.

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