

Knowledge that Heals, Freely

I arrived at Biju's house promptly at nine o'clock in the morning, per his request the night before. It was an hour earlier than our usual starting time. I had only a few more days left in a month of fieldwork at Mookkamangalam, and that day the humidity was already so intense that I had sweated through my well-worn poplin shirt just sitting in the back of the auto-rickshaw on the twenty-minute commute from my hotel. The fifty-rupee note I fished out of my jeans to pay the driver was damp, too, and when I handed it to him and said thanks, he gingerly pinched it by a corner and wincingly asked, "Any others?" "I'm very sorry," I said, "they're all damp," and stepped away to find Biju standing atop the stairs of his front entrance waiting for me. The driver turned from me to Biju, who, with a slight jerk of his head, sent the man away. As the auto's engine kicked back on, Biju commented on the heat. "It's going to be very hot today, so we need to start early." I couldn't help but think it was already very hot and humid, and I tried to waft some air through my shirt by tugging on it a few times.

I kicked off my flip-flops at the bottom of the stairs, and made my way up the steps to join Biju on the veranda, where we talked about the lessons I had observed the day before and some of the recent patients who visited Mookkamangalam. "Do you remember the *lūtāviṣa* [spider venom] patient from Thrissur City two weeks ago, a young girl, eleven years old? The skin on the lower part of her leg was irritated. She came here with her mother and father." I said I did. But I checked my notes anyway, and this brought back a visual of the girl's shin, which my notes said was very red and swollen. At the site where a spider bit her, the skin was slightly depressed, and around it the skin appeared bubbly, brownish-red, and like it could easily slough away when touched. The girl was visibly in some pain, though not a lot, and reported itchiness at the site of the bite. She had a fever, which alarmed her parents, and all three of them were worried that the leg seemed to be getting worse with each passing day.

Biju's students had already left for the day when this family arrived at Mookkamangalam. With no one to question about the young girl's symptoms and treatments for *lūtāviṣa* in the *Aṣṭāṅgahrdaya*, he spoke with the girl's parents, explaining that this was a spider bite, and it would get better. He asked the mother and father about their daughter's overall health, and when he learned it was generally good, he instructed them to purchase several things from the market, and to prepare the ingredients into a medicated oil (*taila*) to apply to the leg. The father said he couldn't remember all of this, and he asked his wife if she had a pen and paper to write it down. One of Biju's students usually writes down these instructions for patients and the people who accompany them. It would have taken me far too long to get this down in Malayalam, and Biju knew that, so he didn't ask for my help. The girl's mother rummaged through her purse and pulled out a pen and what looked like an advertisement on a piece of 8x10 paper. As Biju restated the ingredients to make the oil and how to prepare it, she wrote down everything in the blank spaces and margins of the ad.

The parents were relieved to learn what had happened to their daughter's leg. The girl also seemed comforted to know that the medicine Biju prescribed would make her skin normal again. When Biju finished explaining his treatment plan, the girl's father and mother turned their shoulders away, forming a huddle, and began whispering to each other. The mother pulled something from her purse and surreptitiously handed it to the father. He then reached out his hand to Biju, clutching something in his fist and said, "Thank you. Please take this." I couldn't see what he held. But I presumed it was money. Biju raised his hand to his chest, palm facing out, and shook his head, "No, no, this isn't necessary. There is no charge." Discomfort gripped the parents, and the father again politely asked Biju to take the money. All the while, their daughter sat silently, wounded leg stretched out in front of her, skirt pulled above her knee; she didn't seem to notice the awkward interaction her parents were having with Biju, as she tilted her head side to side to get a thorough look at the blistered skin on her leg.

For most of this interaction I was seated behind Biju on a wooden chair. I'd seen this kind of back and forth many times before with people who visited Mookkamangalam for the first time. When I compared my own experiences with doctors in the United States, as a patient and a parental escort for my son, I understood these parents' wish to give Biju something in this situation. He had taught them what was wrong with their daughter's leg, how to treat it and, equally crucial, he had given them peace of mind. He had allayed their worries about what was happening to the young girl's leg and assured them it was curable, provided they follow his plan. Receiving a concrete therapeutic plan and, oftentimes, comfort from knowing that things aren't as bad as they might seem, especially when my child is involved, are things I have come to expect from my interactions with doctors. I don't expect to get these things for free, however. So, it never surprised me when I observed patients or their relatives and friends try to pay Biju and Priyankara for

their attention, time, and healthcare. But when I initially started visiting Mookkamangalam, I was surprised that they always refused every kind of payment. This time, just like every other time, once Biju insisted this was how it had to be, the patient and her family expressed their gratitude several times, descended the steps of the veranda to rejoin the driver of the auto-rickshaw that had brought them there, and left the compound.¹

Apart from a treatment plan written on a piece of paper that is sometimes provided at the end of a consultation, nonemergency healthcare at Mookkamangalam seldom involves an exchange of anything material. Patients do not usually receive medicines for their disorders, and Biju and Priyankara never accept money for their services. To the onlooker, the only thing that appears to move between the physician and patient is information, and their confab and re-presentation of facts and perceptions move in relaxed yet semi-formulaic ways similar to clinical communications I have had myself as a patient of biomedicine in the United States. That is, as a patient, my perception of my symptoms and experience of disease intermingle with the physician's assessment of my point of view and medical history, which informs her expert evaluation of my condition, leading to an explanation about how to proceed: by monitoring the situation, with treatment, or perhaps with a combination of approaches. At Mookkamangalam, Biju and Priyankara evaluate patient illness narratives and the conditions they present with direct reference to the *Aṣṭāṅgahr̥daya* and, often, sources on *viśavaidyam* they have taught and used in their gurukula many times before.

Discussions that vaidyas and rogins have about the experience of disease, somatic data, and healing knowledge comprise the critical part of gurukula philology that reveals the ongoing lives of old texts in contemporary south India. It's here that a vaidya-guru and students assess and treat patients, colloquializing Vāgbhaṭa's classic along the lines of what, at the end of the nineteenth century, E.S. Sheldon and Henry Sweet called "practical philology."² Specifically, Sheldon and Sweet thought that philological techniques applied to Latin and Greek texts had practicable uses for instructors and students of modern European languages. And while I am describing the use of texts in a medical context, the twofold philological process in both cases is parallel. The vaidya-guru as philologist connects techniques derived from a systematic textual discipline to new and present situations, with actors who can apply (physicians/ language instructors) and who want to receive (patients/language learners) the effects of that discipline to gain a sound grasp of something in the present moment (illness/language) in order to effectively address it. The transmission of knowledge learned and mastered in the philological study of classical texts during gurukula education leads to the application of that knowledge for the express purpose of healing the "diseased [person]," the rogin. In this chapter, I explore this second register of the practice of texts, the necessary and subsequent complement to the preliminary register we saw in the preceding chapter that begins with intense, oftentimes multilanguage textual studies.

Exchanges between vaidya-gurus and patients clarify why some ayurvedic practitioners continue to read their tradition's classical literature. Daily encounters with patients at Mookkamangalam offer distinct examples of how vaidyas like Biju and Priyankara take recourse in classical Sanskrit literature to explain and rationalize aspects of their contemporary healing work. These examples furthermore shed light on bigger questions about exchange relations in Indian history and society and complicate earlier studies and scholars' long-held assumptions about the nature of giving and taking in India generally.

MAUSS AND MOOKKAMANGALAM

A patient consultation at Mookkamangalam calls to mind the classic study of exchange and gift-giving in Marcel Mauss's "Essai sur le don: forme et raison de l'échange dan les sociétés archaïques" (hereafter *The Gift*).³ Which is to say, a contractual *do ut des* appears to be in play between patients and physicians in the south Indian ayurvedic gurukula: the former gives information to the latter so that the latter might give back healing information and treatment plans to the former. After that, the patient does not, indeed is not allowed, to give anything back to the physician, apart from a kind gesture and word of thanks. As a patient of biomedicine in the United States, after I present an illness and relevant medical history that might help a doctor assess my health concerns, I normally expect the doctor to respond by giving me something in the form of a diagnosis and prognosis. If the physician then gives me medicine or a prescription, this act prompts yet another offering from me to the doctor: commonly a monetary payment (which I would give to a pharmacist when picking up the prescription). In my experience, doctor-patient exchanges usually end in this way, and the doctor and I part having fulfilled our obligations in this particular social relationship. The interaction of vaidyas and rogins at Mookkamangalam, however, is fundamentally different.

Although this gurukula stands outside of the network of government-certified medical caregivers in Kerala, it is still for many people no less part of the Indian healthcare system as a clinic I might visit in the midwestern United States is part of the American medical marketplace. Yet, the clinical space of Mookkamangalam *mana* operates almost exclusively in the exchange of data and knowledge and nothing more. Acts of exchange there are not measured and made in kind but, instead, are designed to be unequal and nonreciprocal. These behaviors complicate Mauss's influential theory about exchange and gift-giving, which I use in this chapter as a prompt to reflect on the motivations, rationalizations, and rewards of giving and receiving knowledge and data about the body in the clinical dealings I observed between Priyankara and Biju and their patients.

Growing up, my parents subtly informed me that the nature of gift-giving was supposed to be a one-sided affair. Some of my earliest memories of this lesson are from attending friends' birthday parties. Naturally I had to bring presents to their

parties. I enjoyed the festivities and birthday cake, and Mauss might have argued that this enjoyment was tantamount to recompense for the gifts I gave my friends. But like most kids, I learned not to expect to go home with a gift in hand that matched the gift I gave. Children in the United States and around the world learn this lesson from an early age: a gift-giver presents another person with something that's seen neither as repayment for an earlier exchange nor as an offering meant to elicit a future return from the recipient. In *The Gift*, Mauss argued that actors in gift exchanges might *perceive* themselves to be either givers or receivers of so-called free gifts—offerings unmotivated by self-interest or an expectation of future compensation. But the fact is, there are almost always counter-gifts, even at children's birthday parties. Lapses of time between initial- and counter-gifts tend to make people forget or perhaps be more prone to overlook the actual *quid pro quo* of which their "gifts" were a part. Or, as Pierre Bourdieu noticed, the profit interests of givers are often veiled in euphemism, causing receivers of so-called free gifts not to realize that such gifts are in fact imaginary.⁴ Gifts are never really free, Mauss taught us. Free gifts are not and have not been part of exchange economies in most human societies throughout recorded history, and this applies, Mauss said, to all cultural domains, including medicine. So, after a doctor tenders a prescription or medication to a patient, a counter-offering is ordinarily given from patient to doctor, making good on the social convention of their relationship with symmetrical prestations.

But interactions between physicians and patients at Mookkamangalam destabilize the universality of Mauss's observations about gift-giving. These relationships are based on a tenaciously asymmetrical system of exchange in which a vaidya gratuitously gifts knowledge of classical life science to a rogin, who pays nothing for it. If we follow the mandate laid out in the Sanskrit medical classics, to which I return later, an exchange of equal gifts in an ayurvedic context runs the risk of invalidating the intent, use, and healing capacity of the knowledge the vaidya conveys.

In the exchange of health data and healing knowledge at Mookkamangalam, the Maussian understanding of the gift is at once corroborated and complicated. Mauss argued that an obligation to reciprocate an offering, immediately or at a later time, was a regular facet of archaic societies. He intended this general observation and the sociological theorization he applied to the forms and reasons for exchange to serve as a prehistory of economic and legal contracts that were also found in most modern societies.⁵ Despite the overall validity and applicability of his theory in both premodern and modern societies, ideas about exchange in India—in classical literary explanations and contemporary observation—diverge from Mauss's hypotheses about why and how people give and take. The Sanskrit conception of *dānadharma*—the "duty" (*dharma*) of "giving" (*dāna*)—has influenced the nature of exchange in Indian societies for centuries, especially impacting religious communities of Hindus, Jains, and Buddhists, and it does not permit

the kind of reciprocity that Mauss thought undergirded the giving of gifts in most societies. The back and forth movement characteristic of exchange economies in his analyses is instead anathema in classical Indian articulations of *dāna*, which is an expiatory gift offered to someone who is specially authorized to receive it. What is more, an act of *dāna* establishes neither an obligatory bond of reciprocity nor an equal relationship between givers and receivers. Axel Michaels suggested that “wherever reciprocity is practised, it is not a case, in India, of religious *dānāni* but of profane exchange or trade.”⁶ Profane exchange or trade is not *dāna*, although it agrees with Mauss’s model of gift-giving. Conversely, *dāna* is nonreciprocal exchange that is inimical to Mauss’s model.

Mauss knew that the history and practice of *dāna* in India did not align with his ideas about exchange. In W.D. Halls’s translation of *The Gift*, Mauss’s most telling reflection on what has come to be known in scholarship as the “Indian gift” (*dāna*) appears in the famous footnote 61 of his classic study. In this lengthy footnote, he refers to passages in the *Mahābhārata* and treatises on *dharma* (*dharmaśāstra*) that forbid the reciprocation of certain gifts, especially gifts to Brahmins, pondering the outlier status of the Indian gift to his general theory of gift-giving.

Concerning the main subject of our analysis, the obligation to reciprocate, we must acknowledge that we have found few facts in Hindu law, except perhaps *Manu*, VIII, 213. Even so, the most apparent fact is the rule that forbids reciprocity. Clearly, it seems that originally the funeral *çraddha* [sic], the feast of the dead that the Brahmins expanded so much, was an opportunity to invite oneself and to repay invitations. But it is formally forbidden to act in this way, for example [in the *Anuśasanaparvan* of the *Mahābhārata*] lines 4311, 4315=XIII, reading 90, lines 43 ff.: ‘He who invites only friends to the *çraddha* [sic] does not go to heaven. One must not invite friends or enemies, but neutral persons, etc. The remuneration of the priests offered to priests who are friends is called demoniacal (*picaca*) [sic]. . . .’ The cunning Brahmins in fact entrusted the gods and the shades with the task of returning gifts that had been made to themselves. Undoubtedly, the common mortal continued to invite his friends to the funeral meal. Moreover, this continues in India in the present day. For his part, the Brahmin did not return gifts, did not invite, and did not even, all said and done, accept invitations. However, Brahmin codes have been preserved in sufficient documents to illustrate our case.⁷

Mauss acknowledged that the prohibition against the repayment of gifts “continues in India in the present day,” underscoring the persistent social authority of classical texts and practices designed to uphold *dharma*, like *The Laws of Manu*, and the custom of *dāna* in modern India. Yet, as examples from Mookkamangalam show, Sanskritic behavioral guidelines are at once vital to contemporary medical practice but rarely reified wholesale. If the spirit of a dharmic-like “medical law” about gift-giving persists in the present day, the letter of that law in central Keralan gurukula culture is also intentionally supple to accommodate varying features and needs of each patient scenario, reference to multiple and perhaps

conflicting texts, and treatment plans that draw from the past clinical experiences of the vaidya-guru.

To explore the idea that knowledge for long life, *āyurveda*, can be a gift, it's instructive to note, with Miriam Benteler, that gift exchange in any context often consists of far more than material things.⁸ Gifts can also be ideas, advice, stories, and participation. The point of all these things, Benteler suggests, is to support social roles and relationships. By exchanging knowledge about health and the body, vaidyas and rogins at Mookkamangalam are situated on the threshold of an exchange economy that has features of Michael's so-called profane trade, involving a classic *do ut des*, as well as features of an asymmetrical social relationship typical of the so-called Indian gift. Although it exhibits aspects of asymmetrical gift-giving, aspects not addressed in footnote 61 of *The Gift*, thus both challenging Mauss's theory and affirming the uniqueness of the Indian gift, the Mookkamangalam example also adds conceptual nuance to, and encourages further analytical elaboration of, the ways that scholars have imagined gift-giving as atypical in India. In the rest of this chapter, I suggest that the gifting of *āyurveda* in the work of Biju, Priyankara, and Bhaskaran is a further example of how the practice of texts shapes their healing practice and, beyond its relevance in the gurukula clinic, how it challenges and problematizes articulations of gift theory in South Asian studies and Classical Indological studies since Mauss's seminal analysis, which tend to treat *dāna* as an inflexible principle in the practical lives of Hindus, Jains, and Buddhists.

VAIDYAS AND ROGINS

Bhaskaran, Priyankara, and Biju were trained mukhāmukhaṃ-style. They did not receive degrees from ayurvedic colleges, and the Government of India never officially licensed them to practice Ayurveda. Nevertheless, each garnered a favorable and quite celebrated reputation as an ayurvedic healer and teacher in central Kerala. Patients found them and sought their advice, and continue to visit Priyankara and Biju at Mookkamangalam, based on these reputations and word-of-mouth referrals. Between 2003 and 2017, the patients I encountered at Mookkamangalam were demographically diverse. I met many parents who brought their sons and daughters for consultations and treatment, like those in this chapter's opening vignette. But the majority of patients were middle-aged men and women. Seniors were seldom there when I was present; if they were, their adult children typically accompanied them. I met Hindu, Muslim, and Christian patients over these years. The vast majority of adults were educated through the senior secondary level (equivalent to high school in the United States), some were college-educated, and most were working professionals from middle- and lower-middle-class backgrounds. Auto-rickshaws and family motorcycles were the most common modes of transport to the Mookkamangalam clinic; occasionally a patient arrived by private car with a driver. I don't recall hearing patients say that they were visiting

Mookkamangalam because the healthcare is free or a religious commitment or duty (*dharma*) led them to Ayurveda because it is “Hindu medicine,” as opposed to the “Muslim medicine” of Unani, for example. These are distinctions colonial administrators made in the eighteenth and nineteenth centuries, European and North American Orientalists carried forward into the twentieth century, and people in India and around the globe continue to make today. For patients and physicians alike at this gurukula, Ayurveda was fundamentally humoral and corporeal. It is medicine for unwell bodies, and health and disease were understood and expressed according to physiological and pathological processes involving diet, the movement and mixing of substances in bodily fluids, and environment. Problems like contact dermatitis, allergic rashes, and inflammatory reactions to insect and spider bites made up the majority of cases Biju and Priyankara had when I was there. More severe and potentially fatal cases, as I discuss in the next chapter, usually involved sickness and trauma due to snakebite.

Most of the patient clientele at Mookkamangalam is from the Thrissur District. Some are from the immediate neighborhood itself and have been going there for years, although I also met several patients who traveled from over an hour’s distance by auto-rickshaw. In the last decade of my visits, 2007–2017, in a normal week Biju would see anywhere from five to ten patients a day. Rarely would a day pass that no patients at all would show up, and those who did come usually just appeared, rarely calling ahead to make an appointment. As I explained in chapter 2, students who are studying with Biju accompany him when he meets patients. After learning the reasons for a rogin’s visit, Biju often puts questions to his students, pressing one after another to connect their knowledge of the *Aṣṭāṅgahṛdaya* and other texts with the patient’s testimony and visible ailments. The Mookkamangalam “team” then briefly confers, and Biju usually asks a series of questions before inspecting the disorder(s). Depending on factors like the patient’s age, level of anxiety, and severity of sickness, his inquiries are sometimes put directly to the sick or injured person, and at other times he addresses their attendants. He tries to establish basic but vital information, such as a patient’s place of residence, profession, diet, elimination consistency, and family health history. Once his questions have been answered, he inspects the actual problem, if it’s a visible wound, and replies with an improvised commentary on what he has learned, drawing on and putting into layman’s language citations from the *Aṣṭāṅgahṛdaya* and *viśavaidyam* sources. When students shadow him, he might ask one of them about the problem first, correcting and adding nuance to their diagnosis, before recommending a treatment plan. This “prescription” is a brief memo or command called a *kurippaṭi* in Malayalam. It may be conveyed orally, but often it is written down so a patient can consult it again later. A typical *kurippaṭi* will include things such as herbs, plants, and powders to purchase and instructions for cooking the ingredients into a decoction (*kaṣāya*) for ingestion or an oil (*taila*) for topical application, as well as recommended dosages. With that, a meeting between the vaidya

and rogin ends. Sometimes small talk ensues, especially if the visitors have been to Mookkamangalam before or mutual friends referred them to the clinic, before the patient and his or her entourage depart.

In some cases, follow-up appointments are set for days, weeks, or even months later. More often than not, a return check-up is not planned unless the patient's problem gets worse after the start of treatment or persists beyond a certain time. Because patients and their attendants have been equipped with information needed to correct a particular condition, after leaving the gurukula they can reprocess the knowledge Biju gave them if the same disorder resurfaces. Just as the parents of the young girl from Thrissur City did, in my experience at Mookkamangalam new patients and/or their attendants invariably ask about the fee for Biju's or Priyankara's time and assistance. Every time these vaidya-gurus reply, with a gentle wave of the hand and some variation of the phrase, "Nothing, it's free" (*onnumilla, it saujanyamāṇ*). All medical services at Mookkamangalam are provided *saujanyamāyi*, "for free." Most patients nonetheless try to give Biju and Priyankara some kind of payment, or diplomatically ask one of their students (and even me, on occasion) to take their money. Regardless of their patients' persistence, they insist on accepting nothing—no money or material gifts—for the healing work they do. Even in cases where certain remedies are dispensed on-site to a patient, the same policy about remuneration holds true.

When medicines are administered during a consultation, the give-and-take between the vaidya and rogin is often fraught. The fact that drugs are needed then and there means the patient is seriously ill, maybe even close to death. In central Kerala, such incidents routinely involve snakebites. Someone bitten by a venomous snake might arrive at the gurukula clinic fairly alert, with only a bit of localized swelling at the site of the bite. But sometimes they arrive in semiconscious states and are lethargic or even nonresponsive; conversely, the poison can also have the effect of making the rogin frantic and abnormally agitated. I explore this kind of emergency scenario in the next chapter, where the on-site delivery of drugs initiates a much more elaborate pattern of social interaction than a routine clinical visit. Biju, for example, reacts to a snakebite victim's arrival by promptly retrieving medicinal plants from his yard or gathering prepared drugs from one of the house dispensaries, whereas most of his patients are instructed to prepare and administer drugs to themselves. If his patient's life is on the line, however, he is much more involved, and he vigilantly ensures a rogin takes the drugs he assigns straightaway. Looking back through my years of fieldnotes, pictures, and videos at Mookkamangalam, in both emergency and regular visits I have no record of either Priyankara or Biju applying oils, pastes, or other topical medicines themselves to a patient or in any way making sustained contact with an ailing person. There might be a gentle pat on the shoulder here and there, or a very cautious touch of the skin, especially when the patient is a small child who's uneasy about being ill and uncomfortable being observed. But that is usually all there is, if any contact is

made. Typically, while speaking with a patient or inspecting a skin disorder, Biju has his arms draped behind his back or folded across his bare chest. Priyankara is more prone to gesticulate than Biju, and because she was having problems with her eyesight for many of the years I did fieldwork at their *mana*, she often had to get closer to patients than Biju did just to make sure she was adequately accessing their conditions. Both vaidyas are always respectful, often smiling and pleasant hosts during their patients' short visits, and Priyankara has a special knack for allaying worry in the children at their clinic.

People familiar with the history of Hinduism and the Brahminical concern with purity and pollution described in *dharmasāstra* literature might wonder if such concerns lie behind Biju's avoidance of contact with his patients. There is no simple answer to this. But it is possible, at least in part. The idea that contact with open wounds and bodily fluids, as well as interactions with people from lower classes and castes, is polluting agrees with the customary classic view among scholars that Brahmin physicians of Ayurveda have historically faced: specifically, their social and religious obligations, or *dharmas*, do not match up with their professional pursuits, and vice versa. This incongruity might explain why the practice of surgery and obstetrics in Ayurveda dropped out of the profession around the seventeenth century.⁹ A perceived incompatibility of certain ayurvedic practices with the protection of Brahminical purity has certainly persisted in modern Kerala, most notably among the well-known Vaidyamadham family of *aṣṭavaidyans* from the Palakkad District. P.U. Leela observes that the family patriarch, Vaidyamadham Valiya Narayanan Namboodiri I (1882–1959); his son, Vaidyamadham Valiya Narayanan Namboodiri II (1910–1988); and his grandson Vaidyamadham Cheriya Narayanan Namboodiri (1913–2013) all outspokenly disparaged any type of hands-on or surgical practice in their ayurvedic work because of the probability of ritual contamination.¹⁰ Their prohibition is attributed to the fact that the Vaidyamadham family belongs to the highest Brahmin subcaste in Kerala, the Bharadvaja *gotra*, which is a socio-religious distinction that also sets them apart from the Mooss and Nambi families of *aṣṭavaidyans*, who belong to the Dhanvantari Brahmin *gotra*.¹¹

For his part, Biju does not hide the fact that he is a religious person or that he lives his life as a devout Namboodiri Hindu Brahmin. Most days his attire attests as much: his upper body is often uncovered, apart from the *yajñopavīta* thread; his lower body is usually wrapped in a plain white mundu; and his arms, neck, and forehead are frequently smeared with ash from daily *pūjā* offerings. And yet, this doesn't preclude him from consulting "people from all classes and castes irrespective of the normative understandings on comparative purity and pollution of human bodies."¹² By avoiding most physical contact or by asking a patient's attendants to administer drugs to their sick friend or family member, Biju generally maintains his ritual purity throughout the day. He learned early in his studies from Bhaskaran and Priyankara that the *vedādhikāraṃ* and *yagādihikāraṃ* (authority to teach the Vedas and perform religious sacrifices) of Namboodiri vaidyas were

historically denigrated by orthodox Malayali Hindus because they had regular associations with the sick and impaired. So, for him it's been vital to keep his religious practice and healing work in separate spheres. "My worship and *āyurveda* are unconnected. I separate them," he told me, "at certain times and in certain spaces every day. But if I make contact with a patient or if I reassure an anxious child [by touching his shoulder], that's okay. That's nothing to be afraid of."¹³ He understands the social and historical perceptions of the ayurvedic physician in Kerala, and he tries his best to keep religious-ritual and professional-medical duties distinct and sorted in his mind, with neither one interfering with the other. The absence of physical contact with his patients complements his religious practice. This "distance" also happens to be compatible with, and perhaps supports, the gifting system at play most often at Mookkamangalam, where the polestar of a clinical visit is the flow of data from patient to physician and healing commands from physician to patient.

Jacob Copeman's study of blood donation (*rakt dān* in Hindi) in north India offers instructive insights about the gurukula vaidya's potential reasoning for upholding a knowledge-based gift economy. A physician's orchestration of medical services for patients, especially in crisis situations, makes explicit "those always-present and yet at the same time frequently latent fears concerning the flows of bio-moral qualities between persons," Copeman suggests, since medical contexts bring people "fully face-to-face with the dangers of social contact."¹⁴ This naturally calls to mind the dharmic typology of purity and pollution that has fascinated anthropologists and scholars of Indian religions for decades. In his classic, though contested, expression of Indian ideas about purity and pollution, McKim Marriott argued that in the Indian worldview all people are believed to be exposed to a constant barrage of "substance-codes" that flow throughout the environment and from person to person in the course of daily activities and interactions. In the medical context, avoidance of contact with an ailing patient could be seen as a mindful effort by Mookkamangalam vaidyas to exchange only the most intangible elements that Marriott supposed make people open and porous organisms, rather than self-contained entities. That is, they deal in knowledge exchanged through words, ideas, and appearances folded into the constant transfer and entanglement of particles and matter that move among people. These exchanges, Marriott reasoned, are what make people individual: "always composites of the substance-codes that they take in" day-to-day.¹⁵ Gifting knowledge as a remedy might not result in overt contamination for the Brahmin physician. If we follow the somatic worldview Marriott imagined to its end, however, it would appear that this exchange does contribute to the continual reconstitution of both gift-giver and gift-receiver.

To further situate the gift and gifting, Sanskrit *dāna*, in the medical context of central Kerala's gurukulas, a practice known in Hindi as *auśadh dān*, "medicine gift," which usually denotes charitable giving to the indigent, speaks to the impact that gift-giving has on both givers and receivers.¹⁶ The medicine gift is a

social-medical-religious practice that alleviates people's physical and financial healthcare problems, while also having the added impact of absolving sins of the gift recipients. Ron Barrett's study of the Kusht Seva Ashram (KSA) in Varanasi is a unique case study of *auśadh dān*.¹⁷ Aghori doctors at KSA give their socially ostracized patients with leprosy, leukoderma, and vitiligo—diseases seen by many in north India as the result of grave improprieties, or so-called bad *karma*—a potent mix of what's known in Hindi as *davā aur duā* (“medicines and blessings”). By welcoming and physically embracing these patients, Aghori doctors challenge the perceived pollution associated with these misunderstood dermatological afflictions. They offer psychological and spiritual relief to their patients, who in many cases have been shunned for years because of their appearance and the religious sins associated with their disorders.

KSA patients are not the only ones who benefit from *auśadh dān*. The Aghori doctors also gain something for the healthcare they provide, though it is not a return gift per se. They assuage the social and emotional experience of illness in their patients by embracing and in the process absorbing, symbolically, their diseases. They also take upon themselves the social and religious traumas of rejection and humiliation their patients have endured because of their skin disorders. The Aghori doctors' immunity to disease, and the obvious “polluting contact” they make with patients, is paraded as a medal of these healers' fearlessness and moral integrity. The contact empowers them. By purifying the sick, they uphold what has been long seen as an antinomian agenda to disavow the restrictions of orthodox Hindu purity and pollution laws. An idea like the one Marriott professed in the 1970s about substance-code transference appears unimportant or nonexistent in the lives, work, and religious practice of KSA's doctors.

At Mookkamangalam, the gift of *āyurveda* leads to bodily restoration and general wellbeing. The re-establishment of wellbeing in Biju's and Priyankara's patients also brings a degree of social and emotional restoration among their patients' families and the communities to which they belong. The achievements of physical wellbeing in the patient and the social-emotional renewal are often quite clear. In my experience, however, rarely, if ever, have Biju's or Priyankara's consultations with rogins spilled over into areas of moral renewal or spiritual cleansing for either the healer or the healed. As I noted of Biju, and the same goes for Priyankara, these *vaidya*-gurus go to great lengths to separate their medical work from their religious practice, each of which, they insist, requires a unique frame of mind to perform and offers its own distinctive rewards.

GIVERS, GIFTS, RECIPIENTS

How do we make sense of a gurukula *vaidya*'s behavior in the gifting of *āyurveda* at Mookkamangalam? Is it a charitable act? What motivates Biju (whom I have observed more than Priyankara) to do the work he does without recompense and

in a framework that is, for this observant Hindu Brahmin, potentially polluting? To explore these questions, it is helpful to look at Mookkamangalam through the lens of Mauss's theory of the gift. On the one hand, vaidyas and rogins in the clinical setting of Mookkamangalam engage in a classic Maussian gift exchange. There is a mutual nature to the gifting that serves a basic social function that, Diana L. Eck observes of gift-giving generally, "is more than a gesture of generosity." It is an exchange that establishes connections and patterns of behavior between people and communities, creating "the very sinews of the body of society."¹⁸ A conversational exchange of information about an unwell body starts the interactions: first, in the patient's prestation of knowledge about her illness to the physician, followed by the physician's offering of a diagnosis, prognosis, and prescription to the patient.

On a typical visit to the doctor in the United States, this exchange would not be the end of it. The presentation of a diagnosis and treatment plan marks the first component of a *quid pro quo* of the kind that Mauss identified as gift-giving based on re-compensation. It typically follows that physicians should be paid for their work, and countless Mookkamangalam patients have seemed to believe as much, illustrated by their attempts to give money to Biju or Priyankara and their students. As we will see in the *dharmaśāstra* literature and classical ayurvedic sources, however, if a physician were to take any form of payment, he would reveal himself to be a fraud, uncommitted to classical life science as such, which requires physicians to gift knowledge for long life (*āyurveda*) at no cost to patients or their attendants. If the *āyurveda* an ayurvedic physician gives is matched with a payment of any sort, that healing knowledge is not given as a free, voluntary, or disinterested gift. According to the Maussian model, this kind of giving is constrained by social rules and obligations that are common in medical encounters in the United States, where the things that are given (medicine and money) are based on a long-established system of reciprocity.¹⁹ If that's the system we are used to, we might expect Biju's or Priyankara's gift of healing knowledge to be met with a counter-gift, *viz.* a payment. But at Mookkamangalam they neither receive nor request this—indeed, they firmly oppose it.

Before considering the question about payment for services rendered, the absence of which calls to mind the so-called Indian gift, it is important to underscore the difference and disproportionate nature of the information physicians and patients share. People who are sick and suffering offer individual, intimate, and experiential knowledge of their illnesses. This information is loaded with personal and social anxieties that affect the way and the extent to which patients convey their problems to the physician. At Mookkamangalam, Biju and Priyankara impart information supported by years of textual study and professional activity. The knowledge they ultimately share is based on the collection of current and historical data that patients provide; it is etiological, prognostic, and therapeutic. Such a clear difference explains why a mere tit for tat is often not adequate for many people who visit Mookkamangalam for healthcare, and why I have

seen many patients try to compensate the physician's tat (therapeutic knowhow) with some form of tit (money). Not only is the nature of the knowledge offered different, but the stakes for both parties are also unlike. Patients stand to gain a great deal—health, reincorporation into their communities, peace of mind—by overcoming their illnesses. But what do the vaidyas stand to gain or lose? This question is best understood in view of the decision not to accept counter-gifts for the medical services they administer. This decision is grounded in classical texts, and it is a clear example of the extent to which philologically informed knowledge impacts clinical practice and the vaidya-guru's commitment to promote wellbeing.

At Mookkamangalam the gift of *āyurveda* is tantamount to a gift of knowledge, *vidyādāna*, sometimes called the “gift of learning” according to Indian *dāna* theory.²⁰ The well-known *dharmaśāstra* text, *The Laws of Manu*, held *vidyādāna* to be the highest possible gift one could give, standing “above other gifts of water, food, cows, clothes, sesame, gold and clarified butter.”²¹ The second ruler of the Sena Dynasty of Bengal, Ballālasena, praised the virtue of various types of gift-giving in his twelfth century masterwork, *Ocean of Giving (Dānasāgara)*. Among other gifts, he extolled the giving of land grants to Brahmins for the advancement of Vedic learning and, of note, the gifting of knowledge from teachers to students.²² Unsurprisingly, the idea of *vidyādāna* has been used as a descriptive in contemporary India to express the charitable nature of the teaching profession and virtue of education generally.²³

I asked Priyankara and Biju many times what “medicine”—sometimes indicated broadly as a science (or practice) to identify, treat, and prevent disease and other times pointedly meaning an effective remedy (or cure), e.g., *vaidyam*, *vaidyaśāstram*, *auśadham*, *marunnu*, *bheṣajam*, Mal.—is and how they imagine it to function in the routine encounter with a rogin. The first time I inquired about this I got a quick reply from Biju: “It's *auśadham*.”²⁴ While *auśadham* can mean “medicine” or “medicaments” in Malayalam, it is derived from Sanskrit *auśadha*, which is a collective noun designating the herbs, plants, and occasional minerals that make up healing remedies in Ayurveda. Biju and Priyankara usually use *auśadham* to refer to the contents of a *kuṛippaṭi*. We will see in chapter 5 that the herbal substances constituting ayurvedic remedies constitute one of the four pillars of classical *āyurveda*, alongside the human trio of physicians, patients, and attendants. To say medicine is *auśadham* is thus a reasonable, if a bit textbookish, answer. But over the years, as opportunities increased to talk with Priyankara and Biju in depth and with the ease and comfort that comes with familiarity, I learned that they imagine their use of Vāgbhaṭa's classical knowledge as a kind of *vidyādāna*.

After the young girl with the spider bite left Mookkamangalam in 2014, Biju and I sat on his veranda for a while and talked about medicine and knowledge exchange at Mookkamangalam. I told him that I was struck by how much the mood of the girl and her parents changed from the time they arrived to when they left. When they arrived, they were genuinely worried about the girl's leg: would it actually heal? By the time they left, they were noticeably calm and relieved of their

stress. “They hadn’t even seen the medicine yet,” I said, a little surprised. “They do not need to *see* the medicine,” Biju replied. “Of course, they must apply the *tailam*. But that’s not my job. My grandfather, my mother, and I, we give knowledge. That is *āyurveda* for me. That is what I teach students and, patients also, they are students in a way.”²⁵ When Biju says he transmits “knowledge,” he prefers to use the term *vijñāna* rather than *vidyā*. Both mean “knowledge” and “learning” in Malayalam and Sanskrit. But when he uses *vijñāna* in the gurukula setting, he intends to express a functional overtone to his work and the *āyurveda* propounded in Vāgbhaṭa’s collection, suggesting that what he shares with patients and students in his capacity as a *vaidya-guru* leads to concrete applications and results. He regards *vijñāna* as a type of knowledge that has the capacity to improve the lives of sick people, not only by making them feel better, but also by empowering them. Once they leave the clinic, *kurippaṭi* in hand, patients are outfitted to treat themselves. At Mookkamangalam, the giving of *vijñāna* appears to be a genuine gift, not a *do ut des*, that is designed for selected worthy recipients (*supātras*)—the sick and diseased (*rogins*) and the people who escort them. These people receive this information and depart Biju’s clinic without any obligation to return something to their healer.

Biju and Priyankara know that most people expect to pay for medical care. They also know that many of their patients have been seen by other doctors, often from other medical traditions, such as biomedicine, Unani, homeopathy, as well as Ayurveda, before they visit Mookkamangalam, and in those prior medical visits they normally had to pay for the services they received. From the patient’s perspective, why should the matter of a physician’s fee be any different if one visits a modern medical establishment or a *mana* surrounded by mango trees and rice paddy? It is in this perspectival gulf separating the physician’s and the patient’s views about the nature of exchange and reciprocity that crucial questions emerge concerning the gift in theory and practice in India. Why are payments not accepted or expected for ayurvedic services offered at this gurukula clinic? Are there simply no types of payment that could equal the offering of the *vaidya-guru*’s knowledge, so that a counter-gift like money might taint the gift of *āyurveda*? Do Priyankara and Biju consider the *vijñāna* they give to patients unrequitable? In answering these questions in the medical context of the central Kerala gurukula, features of *dāna* theory directly run up against Mauss’s theory of the gift and shed light on his remarks in footnote 61 of *The Gift*.

A number of scholars have argued that Indian ideas and practices of *dāna* depart from and even resist Mauss’s design of exchange, most notably on the matter of a gift recipient’s obligation to reciprocate.²⁶ Working from the observation of Thomas Trautmann that the *dharmasāstra* theory of the gift “is a soteriology, not a sociology of reciprocity,”²⁷ as it was for Mauss, Reika Ohnuma wrote that *dāna* in Hinduism, Buddhism and Jainism “agrees with Mauss that all ordinary gifts are reciprocal in nature, only to reject such gifts in favor of an asymmetrical, unreciprocated gift that bears fruit in the transcendent future, beyond the present realm

of give-and-take.”²⁸ At its core, classical *dāna* theory says the true gift is neither a part of the social web of reciprocity nor an act that provokes a return. There is no redistribution of resources with *dāna*. It instead concerns issues of moral value. Because the relationship between giver and receiver is always asymmetrical, *dāna* creates what Maria Heim describes as an “ethics of esteem,” fostering interpersonal respect and admiration toward the person on the receiving end of an exchange.²⁹

According to the classical *dharmasāstra* model, in Hinduism *dāna* must go to worthy recipients: traditionally Brahmins, renunciators (*saṃnyāsis*), and holy men and women (*sādhus* and *sādhvīs*). Worthy recipients in Jainism are known as strivers (*śramaṇas*), while in Buddhism the classical portrayal of “beggars,” *bhikṣus* and *bhikṣuṇīs* (monks and nuns), typified the characteristic of worthiness in a gift-receiver. Ballālasena’s *Dānasāgara* classifies worthy recipients according to the moral qualities they possess: they should be known by others, and according to socioreligious conventions and in their speech they should display good behavior, purity, and wisdom.³⁰ In current social practice, recipients of gifts in Indian societies who need not give anything in return usually live ascetic lives and are often people who own nothing, or very little, and have removed themselves from the ebb and flow of commercial society.³¹ The daily offerings of food that lay Jains give to monks and nuns, for example, or householder Hindus give (along with money) to the sea of *sādhus* at the Kumbh Mela readily come to mind in this regard. The monk and the *sādhu*, as Eck puts it, are renunciators who “bear witness to a set of values they place over and against the markets and materialism of the culture at large.”³² The worthiness of a recipient signals the most critical element of *dāna* in both theory and practice in Indian society and religion.

The gift of *āyurveda* that vaidya-gurus give to patients (as well as to students, who are learning to give *āyurveda* to patients) at Mookkamangalam, in contrast, emphasizes something different about worthiness vis-à-vis gift reception: the worthy recipient, the rogin, is someone *in need* of a cure, healing, and restoration. In the ayurvedic context, there’s a concern for neediness rather than worthiness. This aligns with Copeman’s research on blood donation, which shows that contemporary forms of Indian *dāna* like *rakt dān* and philanthropy focus on neediness far more than worthiness as the most essential attribute of a gift recipient. Although worthiness and neediness are not mutually exclusive categories, Copeman’s research helps us extend the classical view of *dāna*, in effect to reformulate the notional value of worth to include need. A powerful result of this extension is that “accountability is built into *dan*,” Copeman suggests, and “efficacy is assured prior rather than subsequent to the gift,” since the criterion of neediness ensures that gifts are offered to people for whom they are likely to provide some kind of benefit.³³

The Sanskrit medical classics address the question of need by delimiting the types of patients who should and should not be treated by physicians. The central concern in the literature boils down to whether or not a patient is treatable.

Which treatments are apt to fail or work for patients? Are patients generally well-informed, and will they be able to follow instructions? Do they have the resources to purchase the *auśadhāṃ* to cure their ailments? Are they likely to follow through with the prescription and recommended doses a physician gives them? And so on, the list of concerns in the classics goes, presenting qualities of “the needy patient” who is and who is not suitable to treat. Reading through the considerations a physician is advised to weigh, it appears that a patient’s so-called need might actually also reflect the needs and obligations of the physician. This intersecting relationship, Dagmar Wujastyk comments, derives “from the perspective of the physician’s needs. Most of the patient’s good characteristics—wealth, curability, obedience to the physician, and fearlessness—pertain to the physician’s convenience: A good patient is one who makes the physician’s job easy and worthwhile.”³⁴ As a result, the classics are ambiguous, and hardly uniform from text to text, about who or what the “patient” is. This could be due to the absence of case studies in the classical sources; I have addressed this curious absence in an earlier project on Sanskrit illness narratives and I take it up again briefly in this book in chapter 5.³⁵

The gifting relationship between vaidyas and rogins at Mookkamangalam is unidirectional, and thus it accords with classical *dānaśāstra*, or rules of giving. Knowledge moves from the gift-giver to the appropriate gift-receiver, and the latter is not obliged—indeed not allowed—to make recompense for the gift(s) received. But it might seem odd that the gift of *āyurveda* moves from physician to patient, since the exchange relationship in the south Indian ayurvedic gurukula stands the classical connection of giver and receiver on its head by making neediness the primary criterion for receiving knowledge for long life. How, then, can we make sense of the nature and role of the gift-giver in this exchange, the Namboodiri Brahmin healer, whose gift, freely given, might on first glance seem out of place in the professional practice of medicine? Epic Hindu literature offers us one of the most basic and well-known directives concerning the “ethic of the donor,” when Krishna explains to Arjuna in the *Bhagavadgītā* that one must, above all else, comprehend one’s role on earth.³⁶ That is a person’s essential duty (*dharma*). Having learned that, Krishna explains that people should renounce all desires for the fruits of their actions in pursuit of upholding *dharma*, acting selflessly and making their actions sacrificial offerings of devotion to their chosen deities, while forsaking the potential positive outcomes of what they have done. The Malayalam verb *upekṣikkuka* expresses a person’s intention to give up or forsake something, such as payback after giving a gift. It signals disownment or the renouncing of something from one’s possession. At Mookkamangalam, *upekṣikkuka* exemplifies an act of professional austerity: vaidyas take nothing, neither goods nor money, in return for their gifting of healing knowledge to rogins. Yet it’s also more than austerity. It is a veritable “relinquishment of . . . proprietary rights in the property” of ayurvedic knowledge itself, insofar as they educate, equip, and empower

sick people with an awareness of their bodies and a therapeutic competency that enables them to treat themselves.³⁷

The knowledge patients present at the start of a gurukula consultation with Biju is obviously not given unselfishly. They expect and need something in return. The physician's *dāna*, however, is an ostensibly altruistic offering, an act of generosity that falls within the ambit of Hindu, Buddhist, and Jain articulations of the giver of *dāna*, whose gift-giving, Peter Harvey observes, "forms a basis for further moral and spiritual development."³⁸ Mookkamangalam patients are worthy recipients by virtue of their somatic and mental needs, while gurukula vaidyas are sacrificers, seekers, and strivers for moral development by virtue of their gratis gifts of ayurvedic knowledge to properly designated recipients.

GIFTING KNOWLEDGE FREELY, OR THE AYURVEDIC GIFT

The proposal that any gift is genuinely nonreciprocal is bound to raise suspicions. What is the point of engaging in ayurvedic practice if there isn't compensation for seeing and treating patients? Biju and Priyankara also do not (and Bhaskaran did not when he was alive) accept money for the Sanskrit and textual training they give students. More than once Biju made it clear to me that, as Bhaskaran used to tell him, the Sanskrit classics say that Ayurveda should be practiced charitably, without taking any money from sick and impaired people. The classics do say this. But they say it in more ways than one, and not every source agrees about the "*dāna* rule" of offering medical services freely. Even still, this was the understanding of the big trio regularly summoned by Priyankara and Biju whenever I asked or a patient insisted on paying for their help; their students have learned to promulgate this rule as well, at gurukula clinics if not in their professional careers, wherever it has been feasible.

The *Carakasamhitā* identifies a medical imposter as anyone who, firstly, attempts to heal without much knowledge and, secondly, who does so primarily for financial gain. The text's compilers differentiate so-called quacks from bona fide healers (e.g., *vaidyas*, *bhiṣajs*, and *cikitsakas*), and Dagmar Wujastyk identifies two particular types of quacks in the literature: "One is a deluded person who wrongly, though perhaps innocently, believes himself to be a physician. The other is someone who knows full well that he lacks knowledge and skill yet viciously persists in practicing medicine."³⁹ In either case, patients suffer. Meanwhile quacks still take payment for their failures; they incongruously brag about their abilities despite their failure to heal; and they take no responsibility for poor remedial results, but instead blame their patients. The *Carakasamhitā* distinguishes a fraudulent ayurvedic healer as one who, after his therapies fail, points out that it wasn't his fault but "the patient himself who lacked equipment, helpers, and the right attitude."⁴⁰ Fault and failure always rest with patients wherever quacks are involved.

There is some ambiguity and contradiction in the literature about livelihood and the acquisition of money for the work ayurvedic physicians do. The *Carakasamhitā* has statements that could be given to support arguments both for and against the acceptance of money for healthcare. The compilers of this collection were perhaps ambivalent about ayurvedic practice and income, and/or quite possibly their views about whether or not physicians should accept money changed over the course of the time during which they assembled the text.⁴¹ They were unequivocal, however, in their assessment that money should not be the physician's primary motivation for offering treatment. Bhāvamiśra addressed the matter with a bit more conviction in his medieval text, the *Bhāvaprakāśa*. For example, Dagmar Wujastyk interprets his statement "one who does not recompense for bodily treatment is a fool" to mean that ayurvedic physicians should expect payment for the good work they do and also, possibly, even recognition for doing it.⁴² Earlier sources occasionally discuss criteria for who should and should not receive payment for their medical work, quacks or honest vaidyas.

The answer to these questions about payment for ayurvedic services sometimes boils down to the social class (*varṇa*) of the healer. In the *Sūtrasthāna* of the *Carakasamhitā*, we learn that only physicians of the Vaiśya class should practice *āyurveda* for money, whereas Brahmins and Kṣatriyas should practice for free.⁴³ Yet, Kenneth Zysk describes a fifth-century-CE Chinese traveler in India, Faxian, who witnessed Vaiśya families in Pāṭaliputra dispensing "charity and medicine" to the poor, diseased, and handicapped.⁴⁴ Scholars of India's Sanskrit literature have known for a long time that the big three classics (*bṛhatrayī*) we have today are products of numerous revisions, interpolations, and emendations, and that these accretions and changes occurred over centuries. Consequently, they present some inconsistencies and contradictions about things that we might classify under the umbrella of professional etiquette. It is not clear, for instance, even in the case of Brahmin physicians, as Dagmar Wujastyk argues, if the compilers of the *Carakasamhitā* imagined there was supposed to be "a direct transaction between patient and physician, that is, [whether] . . . the physician received payment directly from the patient for each treatment" or if payment might have been made and accepted by another means.⁴⁵

If the *Carakasamhitā* presents too many positions concerning the association of ayurvedic practice and monetary gain to draw definitive conclusions about whether or not the gift of *āyurveda* should be complimentary or a source of income, then the compilers of this collection were relatively consistent and clear in the *Cikitsāsthāna* about why a person would want to pursue ayurvedic medicine as a profession in the first place. "The physician striving for the highest *dharma* should save from pain all patients like they were his own sons," the text explains.

Single-mindedly fixed on *dharma* and eager for everlasting life, the great sages revealed knowledge for long life for the sake of religious merit and for the sake of wealth and pleasure. He who practices medicine neither for wealth nor pleasure, but

rather with compassion for all creatures, surpasses everyone. But the one who deals in the business of medicine for livelihood, he abandons the heap of gold and obtains a pile of manure.⁴⁶

The phrase “for the sake of wealth and pleasure,” *cārthakāmārtham*, in this passage is noteworthy. My translation is based on Jadavji Trikamji Acharya’s edition of the *Carakasamhitā*. It is a widely used and generally dependable edition of the Sanskrit text. Yet the best-known English translation of Caraka’s collection by P.V. Sharma relies on a variant reading here, *nārthakāmārtham*, which changes the translation to “not for the sake of wealth and pleasure.” It is not uncommon to encounter alternate Sanskrit editions across genres of premodern Indian literatures, and ayurvedic sources are no exception in this regard. The example of the variants of this passage alone, setting aside, for example, the possibility of scribal errors in the transmission of this early part of Caraka’s *Cikitsāsthāna*, displays the philological challenges involved in defining a particular work-related component of the medical profession in classical India. But we have to work with what’s available and, so, we may interpret the two Sanskrit options as suggesting, à la Sharma, that *dharma*—the multifaceted Hindu principle defining a person’s social-legal-religious duties—is the primary aim of the ayurvedic physician (*bhīṣaj*), while wealth (*artha*) and pleasure (*kāma*) are dissociated from the practice of the unrivaled physician. Trikamji’s version instead brings the original intention of the ayurvedic physician’s practice within the ambit of the fundamental Hindu doctrine of *puruṣārtha*, the four valid “aims of human life”—*kāma*, *artha*, *dharma*, and *mokṣa*.⁴⁷ The choice to follow either version reveals a conviction about where one positions the dissemination of knowledge for long life along a spectrum that holds medicine-as-vocation at one pole and medicine-as-livelihood at the other.

The norm of *dharma* lies at the heart of the notion of medicine-as-vocation. The physician who strives for the “highest *dharma*” (*dharmamanuttamam*) is marked by “compassion for all beings” (*bhūtadayāṃ*). That the compilers of the *Carakasamhitā* appeal to compassion as the physician’s duty, rather than a financial motivation, is suggestive of the long-held hypothesis in secondary literature on Ayurveda that the Sanskrit medical classics display a distinct Buddhist influence.⁴⁸ To this end, the Four Noble Truths (*catvāri āryasatyāni*), which encapsulate the Buddha’s teaching on compassion—namely, the wish that all beings be free from suffering—are often cited. Hendrik Kern argued over a century ago in the *Manual of Indian Buddhism* that the Four Noble Truths were known among the compilers of the *Carakasamhitā*, evidenced by their resemblance to a fourfold division of healing knowledge.⁴⁹ Compare, for instance:

Four Noble Truths: (1) all existence is *duḥkha* (dissatisfaction or suffering); (2) the cause of *duḥkha* is thirst; (3) putting an end to thirst stops *duḥkha*; (4) the way to eliminate *duḥkha* is by following the Eightfold Path.

The best physician possesses the fourfold knowledge of cause, symptomatology, healing, and prevention of diseases; he is fit for [healing] the king.⁵⁰

Kenneth Zysk investigated Kern's claim, noting several flaws in his argument. Following the pioneering research of Albrecht Wezler, Zysk provides a good sense of the enormity of influence that Kern's scholarship has had on Buddhologists who "blindly followed" his claims.⁵¹ A different passage in the *Carakasamhitā*, however, could be read as indirectly drawing on the Buddhist concepts of suffering (*duḥkha*), impermanence (*anitya*), and non-self (*anātman*), and arguably expressing an early philosophical position in Ayurveda on the nature of human existence:

Everything that has a cause is suffering. It is not one's own. It is temporary. It is not created by the self. Yet it arises as one's own possession. Once the true knowledge that I am not this and this is not mine arises, with that [knowledge] the wise man overcomes all suffering.⁵²

The Buddhist ideal of offering compassion to all living beings—whose lives are indelibly marked by suffering—lends itself well to the present discussion about gratuitous gifting of healing knowledge. The absence of any recompense, indeed the insistence that there be no repayment, could suggest that Biju and Priyankara view their work as vocational. The gifting of *āyurveda* is done for the simple, if generous, purpose of helping people overcome their suffering.

Given their unwavering responses to my inquiries year after year about not accepting payment for what they give to and do for rogins, it should come as no surprise that Biju and Priyankara tend to see their work in line with the P.V. Sharma rendering of the Sanskrit text. They are motivated to practice Ayurveda as a dharmic obligation in a socio-ethical sense. Their work is a form of compassion, meant to ease the suffering of the ailing and infirm. That they take no money might also speak to their self-awareness as bona fide vaidyas in the august vision of the Sanskrit classics. But at the risk of being overly cynical, it is also noteworthy that Biju and Priyankara have other sources of revenue, both agricultural and religious, available to them through Mookkamangalam *mana*.⁵³ The security of their economic situation provides an explanation for their ability to refuse all payments for their medical work. It does not speak in full, however, to why they resist the generally inherent, if socially unstated, expectation that people have to receive gifts after giving them and to give gifts after receiving them. This is the social circumstance of *do ut des* or, in Mauss's terms, the "total services" of human societies, archaic and modern, that characterize gift exchange.⁵⁴ In Malayalam, this kind of exchange is known as *sammānam*, a gift that's offered between equals in the sense of trade or mundane exchange. Because Sanskritic *dāna* is thought to contain the "spirit" of the person who gives it, this unique Indian gift becomes a form of self-sacrifice. Just as a Vedic sacrificial victim stands in for the sacrificer, likewise in the act of *dāna* "the gift is a surrogate for the donor," Jonathan Parry argues, for which "no return of any earthly kind is countenanced and even an increment to the prestige of the donor weakens the gift."⁵⁵

There are therefore clear reasons to view the work of the central Keralan vaidyaguru as dharmically motivated, even a kind of charitable offering to those who truly need it. But to what extent is it appropriate to see the gifting of knowledge

for long life in the ayurvedic gurukula—*āyurvedadāna*, as it were—as a kind of traditional *dānadharma*? There are two overarching markers of *dānadharma*. Biju and Priyankara follow one and contravene the other.⁵⁶ Their gifting of *āyurveda* is nonreciprocal like classical *dāna*, on the one hand. It must be unidirectional for the reasons noted above, not the least of which is the belief that treatment administered primarily for compensation is usually the work of dishonest charlatans and little more than flimflam. On the other hand, Jonathan Parry writes that a donor in the Indian context “should seek out the reluctant recipient and give freely” because “the genuine gift is never solicited.”⁵⁷ Biju’s or Priyankara’s gift of *āyurveda* differs from this point. The movement of benefits in their interactions with rogins runs counter to examples in the literature on *dāna*, where sanctified or learned persons reluctantly receive gifts they are not expected to reciprocate. At Mookkamangalam, rogins receive without reciprocating. Biju and Priyankara do not lobby for patients, and their patients naturally are not averse to receiving their healing knowledge. These exchanges nevertheless still evoke the so-called Indian gift, since *āyurveda* is given gratuitously, without expectation of recompense among people united in an asymmetrical relationship. Neediness rather than worthiness is the fundamental criterion of the gift receiver (although it’s notable that in the clinical setting, neediness for healthcare is precisely what makes patients worthy of a physician’s healing work). And yet, because the receiver self-interestedly pursues the gift-giver’s *āyurveda*, the Mookkamangalam case also complicates, if not flouts, this aspect of the Indian gift. The ayurvedic case of giving and receiving is far from straightforward in either the Maussian sense or in the paradigm scholars have long held about the Indian context.

Moving from the practice of gifting healing knowledge to the theoretical presentation of the physician-patient exchange in the classical literature, the *Carakasamhitā* asserts the following: “There is no gift to compare with the gift of life. The practitioner of medicine who believes that his highest calling is the care of others achieves the highest happiness. He fulfils himself.”⁵⁸ This passage submits that by virtue of the ability to heal freely, in giving the gift of *āyurveda*—to patients and students—the vaidya-guru is actually compensated in a way. It is reasonable to ask whether fulfillment and happiness qualify as return gifts for the gift of *āyurveda*. This question in turn rouses other questions and points to other avenues for further study concerning benefits and the gift in ayurvedic theory and practice. What, for example, is the relationship between the emotional and moral outcomes experienced, perhaps even pursued, by the vaidya-guru who gifts *āyurveda* free of charge to ailing patients and aspiring vaidyas? Do the rewards of happiness and fulfillment in some way lessen the force of the free gifting of knowledge for long life? Do these rewards undermine the component of classical *dāna* ideology in the ayurvedic exchange of knowledge between physicians and patients? Moreover, who or what gives these potential gifts of fulfillment and happiness to

vaidya-gurus in exchange for their gifts of healing knowledge? Are they not self-generating, according to the above quote from the *Carakasamhitā*?

While physicians at Mookkamangalam acknowledge and abide by certain millennia-old notions of exchange that bring together socioreligious views about *dharma* and professional standards concerning remuneration and ayurvedic practice, when textual theory merges with clinical necessity, they rarely reify textual injunctions in Sanskrit texts across the board in their daily work. Here, we see that in spite of attempts to interpret the gift according to “processes of systematization and instrumentalization” based on models and scenarios proposed in texts, each instance of gift exchange is not “reducible to or definable in terms of these processes solely.”⁵⁹ Out of this observation that Jacob Copeman made about *rak dān* in north India, a methodological truism surfaces: ethnographic considerations enrich philological inquiry. The union of fieldwork and philology encourages analytical equipoise and eschews the liability of assigning undue or rigid influence to classical texts in people’s everyday lives. When context-sensitive social categories underline an exploratory theory like the gift and analytical categories such as worthiness, recipients, reciprocity, and so on, it is essential to have a polythetic study that examines how people think about and say they use classical texts, as well as how they actually use them (or don’t use them), in their day-to-day activities.

Biju routinely appeals to the classics to explain and justify his work. But he invokes these sources primarily as fountainheads to be extended and adapted via impromptu interpretation and practice, using vernacular ideas and idioms, according to the particular needs of his patients and students. If the texts’ influence is foundational, their implementation is changeable. Hence, although students at Mookkamangalam learn many of the topics covered in Ayurveda’s Sanskrit corpus, from botany to disease causation, doctorly etiquette to the impact of the environment on human welfare, and much more, their most important lessons pertain to the epistemological frameworks the texts provide to see problems and situations clearly and to work through each one anew, according to the particular facets and challenges before them. Textbook theory and on-the-ground experience are complementary, and they have been yoked for generations in central Kerala gurukulas, including at Shantimana and Mookkamangalam. The texts postulate ways to organize knowledge and think through medical problems that are both methodical and supple and serve gurukula students well when they leave and attend to patients in different settings.

Scholars have known for a long time that texts are important in Indian history and society. Contemporary ethnographic studies help us unearth essential points on which the significance of texts depends. Observing Biju’s practice of texts, for example, we find the question of *dāna* cannot be reducible to a case of *śāstric* literalism, a position arrived at all too often when textual studies alone are used to determine the nature of practice. He follows the models of his mother and

grandfather. He gives healing knowledge freely, at once indicating *dāna* and evoking Mauss's concessional footnote 61 about Indian exceptionalism vis-à-vis a universal theory of the gift. Though buttressed amply by sometimes conflicting textual precedents, gifting *āyurveda* at Mookkamangalam implies that the so-called Indian gift too, as a theory of human interaction, is frequently prone to over-generalization. The gift of *āyurveda* is an Indian gift, to be sure, and in this way it is an exception to Mauss's general theory. But it is additionally unique among classical archetypes of *dāna*. Adding nuance to Mauss's theory as well as the Indian ideal, in the ayurvedic context the gift takes us away from the largely religious domain of *dānadharma* in Hinduism, Buddhism, and Jainism, which posits a unidirectional movement of gifts from laity to mendicants, and opens up the Indian gift to social and professional relationships and ordinary aspects of human existence like affliction, neediness, compassion, and an unending awareness of social contracts. Here we continue to see that Ayurveda can be good to think with, to theorize not only questions of education and philology but also the bases motivating human interactions and engagements. In the next chapter I explore another case study, looking at the space of Mookkamangalam gurukula to discover how the practice of texts sometimes materializes in emergency situations and to ask if medical practice in the south Indian gurukula can inform our understanding of ritual and what constitutes ritual activity.