4

From Healing Texts to Ritualized Practice

I had grown accustomed to taking lunch in Mookkamangalam's front sitting room between 2003–2017 when I did fieldwork in central Kerala. I always sat on a short wooden chair, my knees jutting high above my waist, in front of a round table with a vinyl tablecloth that was positioned underneath the ceiling fan for maximum breeze-effect. I'd wash my hands over the edge of the veranda using a bucket of water and a bar of soap, and take my seat while Biju or Priyankara stood next to me, waiting to set the table. A large freshly cut banana leaf lay on the table as my plate, still wet from washing. It dried quickly under the fan, and as soon as it did Biju would heap two or three scoops of hearty *keraḷa maṭṭa* rice onto the leaf and dollop some mango pickle on the side. He would go to the kitchen, and Priyankara would place some vegetables on the leaf and garnish it with a crispy poppadum atop everything. Normally, they would leave me alone for twenty minutes to eat, while they ate together in the kitchen with other family members. I don't know how many lunches I had like this over the years. Nearly every one was the same, with a small rotation of veggies depending on the season, and they were always delicious. If I happened to be feeling any gastrocolic disquiet, as I often did in my early visits to Kerala, Biju would insist that I drink buttermilk after the meal to calm the rumble, and that usually did the trick.

On a particular day in March 2015, lunch at Mookkamangalam was a bit different. Instead of eating with his mother and the other family members at the *mana* that day, Biju joined me in the sitting room. As I hunched over the table ready to eat, he sat down on the wooden bed frame to my left, slowly leaning back onto the rolled-up cotton mattress wedged along the wall. "You're not eating lunch today?" I asked. "We had a late breakfast, and I am not hungry. I'll eat later. Don't worry," he said. Normally whenever I was alone at this time, I would revisit events of the morning as I ate, making mental notes about gaps in my notetaking that I should

address later in the day when transferring my handwritten notes to my computer. Biju sat silently as I ate, occasionally glancing at his mobile phone. I must have felt a little uncomfortable with the silence, and because I was eating alone but wasn't alone, I felt compelled to voice my thoughts. "I'd like to write something about the clinical work you and your mother do here," I said, "about the interactions you have with your patients."

"What do you think we are doing here? We are vaidyas. We study *āyurveda* and practice it. What more is there to say?" Biju smiled as he said this, placing his phone on the bed frame and crossing his arms across his bare chest. I stopped eating, dangling my right hand over the banana leaf, and answered: "There are things you and your mother do when you treat patients that seem to follow patterns. I've been coming here for many years, and I see a routine that I think will interest people who study medicine, healing, and ritual." "Ritual," he replied with a puzzled look. "What do you mean?" "Well, that's actually the feature that I'd like to write about. This is an important type of practice anthropologists and scholars of religion have been wrestling with for more than a century. The work you do with rogins reminds me of some of these studies and makes me think about the nature of ritual in new ways." Biju chortled, and shook his head. Then he asked if I wanted more food.

I did not find his non-reply dismissive or trivializing. He and I had had this type of conversation many times before. He rarely shared my interest in theorizing what happened at Mookkamangalam. "That's okay," he eventually said. "I don't know if what we do is ritual or not. You can tell me, and we'll see. I'd rather talk about what the texts say and how that looks when we treat patients." "Yes, that's great," I eagerly offered, "that's important to me and also important to how I understand ritual. Some techniques you do are especially instructive . . . the attention you give certain patients, like snakebite patients, they require special assistance. Do you remember when I was here five or six years ago and you had to use blowing treatment on a couple patients who were bitten by snakes?" "Yes, that is *ūtu*," he said. The treatment these people received, *ūtu*, offers a good example of my thinking about ritual, and I told Biju that I wanted to write about how his grandfather talked about *ūtu* and how *ūtu* is practiced as a way to clarify scholarly attempts to define "ritual" and use the term to explain human behavior. "Okay, let us see," Biju laconically put an end to the conversation, and he invited me to wash up and take a rest on the swinging bed before mukhāmukhaṃ lessons resumed in the adjoining building where his students waited.[1]

It is uncommon to see acts of the ritualist and acts of the physician described in similar terms. There tends to be a perceived difference of purpose and performance in institutions of religion, where we find the ritualist, and institutions of science, where we generally find the physician. This division lies at the heart of this chapter. I examine a procedure for treating serious cases of snakebite called *ūtu*, "blowing [away disease]" or "blowing [therapy]" (from the Malayalam verb *ūtuka*, "to blow"). I suggest that religious and medical ideas about ritual can

actually unite on the matter of healing, and the language used to show this union need not take recourse in any one domain of culture or academic field of inquiry. To set up the example of *ūtu*, I first explore ritual theory in religion and medicine, asking why analyses of so-called medical or healing rituals habitually draw on theory and language from religious studies to describe an act as ritualistic. Is this borrowing conducive to describing the physician's range and manner of practice? Does the use of religious-studies terminology help to resolve differences between the activities of the ritualist and the physician? Or does this borrowing propagate another enduring assumption that pervades the academic study of religion, too often without critical attention, and its allied subfields, including the anthropology of religion, history of religion, psychology of religion, and sociology of religion: namely, that the identification of ritual implies a religious context?

Andrew Strathern and Pamela Stewart contend that "it is in the sphere of ritual that most questions arise regarding traditional medicine." The attributive "traditional" is key to their observation. They use it as a blanket reference to many, if not most, healing traditions that are not biomedicine. Thus, in South Asia, Ayurveda would be a traditional medicine. Unani would be another, and so would Siddha. Strathern and Stewart's statement rests an old and now almost natural association of ritual with religion in academia and popular media, the perception of which has made it difficult for biomedical practitioners to perceive rituals in their practice, or for others to acknowledge ritual in biomedicine, because rituals are seen as "superstitious nonsense" instead of "valuable therapeutic functions."[2] In part, in this chapter I would like to nudge the discussion of ritual away from the academic study of religion. The presumption that religion naturally undergirds ritual activity has had the unhelpful consequence of preserving a view in medical institutions that ritual acts are irrational, hence unscientific, insofar as they are thought to be linked to transcendent entities for their efficacy. In the medical context, this association is anathema to physicians and scientists, who generally insist that their work is grounded on verifiable laws of cause and effect, laboratory experiments, and randomized controlled trials (RCTs).

After considering examples of ritual in religious studies and the social scientific study of medicine, I reflect on the practice of texts at Mookkamangalam to propose a practice-oriented understanding of ritual that is flexible and amenable to the task of making sense of activities and interpersonal interactions across multiple spheres of human culture. Religion is of course a part of human culture, and the components of ritual I put forth and describe can be helpful to comprehend elements of religious practice and performance. That said, I analyze a healing practice to upset the presumption of a natural or expected attribution of ritual to religion. I do not deny that there are rituals in religion, but at the same time, I also want to present a clear distinction between ritual and religion. This distinction, some might observe, is not entirely new to the discipline of anthropology, as will soon be clear from my review of the literature. But in the field of religious studies the distinction is far too rarely made. There are historical reasons for this, and I

trace some of the foundational theorists in the current and past centuries who helped form and fix the connection of ritual and religion that persists in a lot of writing about religion today.

By utilizing an example of ritual from a medical context, I show that rituals per se convey power and meaning that are not necessarily tied to religion. The ayurvedic case study serves as a foil, therefore, to clarify the relevance of ritual as an analytic category beyond the cultural institution of religion and the academic field of religious studies. Medical anthropological research can enlighten the study of ritual in religious studies, and perhaps even encourage a more mindful approach to the use of ritual in the study of religion. Anthropological scrutiny of a "traditional medicine"—to use Strathern and Stewart's label, which often conveys intangible notions of spirituality and holism versus the empirical science of modern biomedicine—that is grounded in practice and performance theory can illuminate human interaction and activity in multiple cultural domains. To show this, I scrutinize and ultimately avoid language pervasive in religious studies, language historically linked to dichotomous universals like sacred-profane, otherworldliness-thisworldliness, and good-evil. To that end, Kaja Finkler's study of similarities and differences between spiritualist healers and biomedical doctors in Mexico is helpful to accentuate the utility of practice theory to explain ritual irrespective of the segment of society in which we find it.[3] Especially important to my depiction of ritual is Finkler's observation that, at bottom, rituals function to identify and possibly resolve conflicts and problems.

Rather than looking across multiple healing techniques that I watched Biju, his mother, and grandfather perform over the years, to keep the discussion on point I focus on the blowing therapy of *ūtu*. Parsing the performance and various activities of *ūtu* occasions the opportunity to articulate a practice-oriented account of ritual, the three components of which (sociality, reformation, and cynosure) I present in detail at the end of the chapter. The technique of *ūtu* arises at Mookkamangalam exclusively in emergency situations, differentiating it from the routine give-and-take of gifting healing knowledge (*āyurveda*) that I discussed in the previous chapter. While snakebites are fairly common in parts of south India, blowing therapy has occurred only twice while I was in the field in south India, and I missed them both. Both occurred in the evening, one time after I had left Mookkamangalam for the day and returned to my room for the night and once when I was in Thiruvananthapuram visiting the Government Ayurveda College there. I discuss these two cases, how they were described to me in the days following the procedures, and how I have continued to learn about the technique from Bhaskaran and Biju since then.[4] Quotidian events at Mookkamangalam could also illustrate the three elements of ritual I develop in the following pages. But they do so less obviously than *ūtu*, which demands a lengthier and more pronounced set of performed acts than the day-to-day activities at the gurukula.

WHY THEORIZE RITUAL IN MEDICINE?

The impulse to problematize ritual and the association of ritual in medicine emerged early in my observations of ayurvedic gurukulas and colleges. One incident in 2004 at the Government Ayurveda College in Thiruvananthapuram rooted the idea. I lived near the college in 2004–2005, and I had recently been authorized to use the its library and speak with faculty members and graduate students. I was there regularly when I was not spending time with Biju and Priyankara that year, working on a project examining the role of narrative in the Sanskrit medical classics, which evolved into my dissertation and eventually a book, *Somatic Lessons*. After two months at the college, I befriended Ojaayit, an advanced grad student at the college. He had received his BAMS degree two years earlier, and he was doing post-graduate work on the *Carakasaṃhitā*. I frequently ran into him in the library stacks, since we were often consulting the same books. He also introduced me to the college's head instructor of Sanskrit, Prof. Karambha. Ojaayit told me about a workshop at the college in 2003 in which several scholars of Ayurveda in south India, including Prof. Karambha, met to discuss the state of Sanskrit studies at ayurvedic colleges. The event fascinated me, and I asked Ojaayit if the three of us could talk about the conference.

He arranged for us to meet at Prof. Karambha's office. After brief introductions, I explained to Prof. Karambha that I was splitting my time between Thiruvananthapuram and gurukulas in Palakkad and Thrissur. Despite his interest in the Sanskrit language and medical literature, Prof. Karambha was pretty dismissive about the kind of ayurvedic training I was observing at Shantimana and Mookkamangalam. He called it impracticable and antiquated and, belying his own professional commitment to the Sanskrit literature of Ayurveda, he thought the dependence on Vāgbhaṭa's *Aṣṭāṅgahṛdaya* in gurukulas like the ones I'd been visiting neglected a whole century of reforms in ayurvedic education, to their own detriment. When I asked him about his students, he voiced disappointment about their lack of interest. "Students in my classes are eager to complete the first-year Sanskrit coursework and to get on with the 'modern' aspects of Ayurveda," he said. When I asked him about what he meant by "modern," he clarified. "Modern Ayurveda means the allopathy that has been on the BAMS syllabus since the 1970s. The *saṃhitā*s [of Caraka, Suśruta, and Vāgbhaṭa] gave us the theories that still guide Ayurveda [e.g., *doṣa, rasa, dhātu, mala*, etc.]. But exclusive dependence on them is obsolete. The subjects in the oldest *saṃhitā*s are different than the BAMS syllabus, which is like the modern medical schools."[5] Matthew Wolfgram describes attitudes like Prof. Karambha's as "the labor of school-educated Ayurveda practitioners," which "involves the mediation between Indian classical and cosmopolitan theories of the corporeal body and its pathology and treatments."[6] Given the pervasiveness of English language pedagogy alongside an increasing de-emphasis of Sanskrit studies at ayurvedic colleges in the twentieth and twenty-first centuries, and the systematized integration of biomedical

science in ayurvedic education, attitudes about the ayurvedic gurukula like Prof. Karambha's are not unusual today.

Prof. Karambha also said he felt that gurukula training has held on to religious ceremony and ideas, including Dhanvantari *pūjā* and concerns with concepts like *karma* and *dharma*, to explain why some people become ill or why treatments succeed or fail, when ayurvedic colleges have basically abandoned these. He conceded that the history of gurukula education is important to understand the state of modern Ayurveda, and he stopped short of criticizing the work of the vaidya-gurus I had been observing at Shantimana and Mookkamangalam. But he regarded them as an outlying archaism in Ayurveda's evolution. I continued to meet with Prof. Karambha after Ojaayit introduced us, and nearly every time we talked, he unfailingly described a bleak outlook for Sanskrit studies in the ayurvedic college. It was an odd message to get from a professor of ayurvedic Sanskrit in one of India's storied ayurvedic colleges and a man whose livelihood rested on that expertise and his ability to teach a language that he thought students routinely viewed as a nuisance to get out of the way en route to more interesting and practical subjects. But his was not a solitary voice on the matter of teaching Sanskrit in the crowd of college faculty and students. I heard similar ideas and attitudes about the nature of education in Ayurveda echoed by others in Thiruvananthapuram in the south of Kerala, in central Kerala in Thrissur, and further north in Kottakkal and Kozhikode.

In my research on narrative and storytelling as a means to relate bio-physiological issues in Sanskrit literature, including the Sanskrit medical classics, I identified a recurrent handling of bodily disease and health by taking recourse in ethics, divine entities, and religious warrant.[7] I also examined areas in the history of Indian religions where discourses about healing offered creative articulations of important, primarily Hindu, religious doctrine, such as grounding the principle of *dharma* on bodily wellbeing and theorizing *karma* in the current moment rather than in future iterations of a life cycle as a means to preserve health and prevent disease. The collections of Caraka, Suśruta, and Vāgbhaṭa combine an array of explanatory models for health and illness. Many of the professors and students at ayurvedic colleges in south India I interviewed were, on the one hand, reluctant to reconcile apparently unscientific elements of ayurvedic literature with their college educations and, on the other, eager to commend the Sanskrit sources for their wide-ranging ideas about not only the body, but also the entire human condition. Even if the interdisciplinarity of the classics is proof of the vital and enduring place of *āyurveda* in Indian culture and history, in the end, for many people I met working and studying in Ayurveda's collegiate system in south India, particularly those with no personal gurukula experience, the Sanskrit classics complement biomedicine more than amount to a corpus capable of supporting a standalone and self-regulating medicine in the modern era.

My reception of the remarks of Prof. Karambha and others in Thiruvananthapuram connected to the Ayurveda College and my observations at ayurvedic gurukulas in south India more broadly, have been informed by my training and research on religion generally and in South Asia in particular. The categories of ritual and religion are habitually joined at the hip in religious studies research. The studies I am thinking about, which I explore momentarily, are products of scholars working in various disciplines, and many display an old and continuing tendency to use "ritual" as if the very term has self-evident explanatory power, as if its every use inherently carries a meaning so accepted and understood that it requires neither reflection nor explanation. But what does ritual mean? What does the term do when it is used to explain human behavior? I explore the evolution of this association here, drawing on fieldwork at Mookkamangalam to problematize the ritual-religion link and make the case that resorting to the cultural institution of religion and religious (studies) language is not the only, nor is it the most fruitful, option to bring clarity and analytical breadth to ritual theory.

At the outset, I would like to put forth a basic idea about ritual that reappears throughout this chapter. Adam Seligman, Robert Weller, Michael Puett, and Bennett Simon propose a concise yet capacious definition that says ritual is "a unique way of accommodating the broken and often ambivalent nature of our world."[8] I nuance and expand their insight by suggesting that Catherine Bell's notion of ritualization and J.Z. Smith's view of emplacement advance our understanding of the morphology of ritual and its features. Seligman *et al.*'s broad reading gestures toward these advances, and even presages the areas of ritual sociality, reformation, and cynosure I propose below, but does not fully capture them.

The broken and ambivalent nature of being human, at its base, rests on the fragility and degenerative physicality of the human body. Health and wellbeing are aspirations that medicines in general can never attain for their patients completely, and Ayurveda is no exception with its aim of *āyus* ("long life"). The body is in a constant state of disintegration, however slowly and imperceptibly, and the meeting of patient and physician may be seen as a collection of complex sensory experiences that represent, as J.Z. Smith said of ritual in general, "the creation of a controlled environment where the variables (i.e., the accidents) of ordinary life have been displaced *precisely* because they are felt to be so overwhelmingly present and powerful."[9] It is in the course of everyday life, after all, that people confront the infections, afflictions, fractures, and so on they bring to doctors. As Kaja Finkler's social analysis of healing acts demonstrates, rituals help people and communities adjust to—with the aim of correcting—ruptured and uncertain states of being.[10] The clinical encounter illustrates this well and provides useful examples for theorizing ritual as an analytic category apart from the constraints of a single disciplinary source or academic field.

RITUAL AND RELIGION

In a lot of European and North American scholarship, rituals are treated as religious acts, linked to religions, or in some way evocative of religious things, ideas, and conditions. It is thus useful to consider ritual as a classifying tool in the field of religious studies. It's true, as an academic field, religious studies is highly multidisciplinary and filled with scholars trained in historically resolute disciplines like anthropology, history, psychology, and sociology. Pioneering research in these disciplines, in fact, has supplied many of the most tried and tested theories and methods in religious studies over the last century and a half, exploring rituals in "religious contexts" of purification, matrimony, festivals, funerals, and the like. Scholarly trends like these might lead us to ask whether the study of ritual is inexorably linked to the context of religion and religious actors. And if it is, how and why did this association arise?

When Sally Moore and Barbara Myerhoff edited *Secular Ritual* in 1977, the volume ushered in an important and novel explanation of the link between ritual and religion. The book's contributors refused to reduce ritual activity to religious activity, and many of them convincingly argued that ritual is not at all exclusive to the cultural institution of religion. Nevertheless, by making the secular the primary marker of ritual, Moore and Myerhoff also ensured (perhaps inadvertently) that most of the essays in the book retained a vital place for religion in ritual theory. In calling ritual secular, contributors were bound to discuss ritual inside and outside of religion and religious studies. When all's said and done, the book is helpful insofar as it argues that ritual acts can be sacred or secular, religious or nonreligious. But the reader is still left with the sense that secular rituals can only be identified by using language that does not speak of rituals in and of themselves—ritual in its own right, regardless of environment and cultural domain, as a powerful theoretical and analytical construct—but only inasmuch as they display the mirror opposite of acts presented in religions and religious settings.

Some elasticity is always crucial for an analytic category to work meaningfully across the human sciences. By closely examining the idea of ritual as such, as well as vis-à-vis religion and medicine, we can disaggregate longstanding dichotomies like secular-sacred and even medicine-religion, which tend to obscure, if not outright deny, the analytic flexibility and usefulness of ritual across studies of culture. It will be helpful to take note of the foundational theoretical and methodological history that has contributed to the connection between ritual and religion in scholarship and, where possible, correct misidentifications in ritual theory with new case studies. The secular-sacred distinction is a particular ethnocentric division that scholars in Europe and North America have used, and at times continue to use, to explain religion and religious phenomena. A half-century ago, for example, Clifford Geertz famously defined religion as a cultural "system of symbols," while in the early twenty-first century Bruce Lincoln envisions religion as a composite

of four cultural domains: discourse, practice, community, and institution.[11] The list of theories of religion is much older than Geertz's famous definition, and it extends well after it, up to and beyond Lincoln's contribution.[12] But my aim here is not to enter the debate about what constitutes religion per se. It is about when and why ritual was absorbed within the study of religion.

The link between ritual and religion crystalized in the development of the secular-sacred dichotomy decades before Moore and Myerhoff addressed the opposition. It is impossible to understate sociologist Émile Durkheim's influence in drawing our attention to ritual in the social and cultural sphere of religion. In *The Elementary Forms of the Religious Life*, Durkheim argued that religion is "a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden—beliefs and practices which unite into one single moral community called a Church, all those who adhere to them."[13] Within a religion he understood rituals as practices that help people identify with, reaffirm their participation in, and orient themselves toward a community of people with shared beliefs. He thought "primitive societies"—that is, non-European communities—were governed by belief systems grounded on Manichaean worldviews framed by the sacred and the profane, which influenced people's perceptions, shaped behaviors, and determined relationships. The sacred is the ideal, divine principle. It transcends the monotony of the everyday and reflects the needs and welfare of the greater collective, or "the social." In contrast, the profane is mundane and bodily. It corresponds to basic, biological needs like nourishment that reflect the welfare of the individual. Durkheim assigned the performance of ritual activity (or "rites") to the sphere of the sacred, and whether we accept or reject his assessment of societies in *The Elementary Forms*, his book has been and continues to be influential on the study of religion. Scholars have drawn on *The Elementary Forms* and his other studies as points of departure, theories for expansion, and positions to critique, challenging and championing his conclusions about religion, ritual, and society almost in equal measure. In their contribution to the Bloomsbury series "Key Concepts in Religion," Stewart and Strathern's *Ritual* chronicles the critique of Durkheim by a ritual theorist I return to in this chapter many times, Catherine Bell. She dismisses Durkheim's religion-society equivalence as a gross overstatement, for example and famously, like anthropologist Roy Rappaport, she rejects his insistence that categories of thought derive from social forms only, rather than from within all domains of human action.[14]

Rituals are acts oriented towards the sacred, Durkheim believed, and this belief led him to see ritual and ritual acts in religious contexts. Yet, if we can set aside the reductionism and western cultural myopia occasioned by the sacred-profane distinction Durkheim used to frame and describe ritual, and we take his description of ritual in itself (which, importantly, was based on analyses of photographs of Australian aborigines, not his own fieldwork), we can see that the explanation of

ritual in *The Elementary Forms* anticipates what later becomes "practice theory."[15] Durkheim thought ritual acts exist within the actor's frame of reference, and these acts are meaningful to the people who perform them. This view was later refined by Talcott Parsons, who understood the Durkheimian view about the perception of ritual behavior to be consistent with the Weberian notion of *Verstehen* (interpretive understanding). Parsons proposed that ritual situations "must be subjectively defined, and the goals and values to which action is oriented must be congruent with these definitions, must, that is, have 'meaning.'"[16] With this interpretation of ritual perception and circumstances we run into an interpretive problem, however. Is it possible to adduce objective criteria to say for whom meaning exists—for the actor, for the observer, for both—not to mention the content of Parsons's so-called meaning? If the meaning has a religious or sacred nature, then we furthermore need to address questions concerning the constitutive nature of the sacred as well as religion, so that we can know what is and what is not sacred and religious.

Sticking with the Durkheimian position that classifies rituals as actions necessarily oriented towards the sacred, and presuming for the moment that scientific activity would not fit this basic criterion, it might seem that we are left with no option but to relegate the work of physicians to the realm of the profane. Seemingly unoriented to the sacred, and instead fixed to somatic inquisitiveness and a commitment to healthcare, medical and religious acts are like proverbial apples and oranges, incommensurable. A sacred-profane dichotomy assigns meaning to actors according to whether they position their actions either toward or away from the sacred, and thus it inevitably describes an incomplete worldview. Roger Caillois observed this in *Man and the Sacred*, when he wrote that "the profane, in relationship to the sacred, simply endows it with negative properties. The profane, in comparison, seems as poor and bereft of existence as nothingness is to being."[17] Caillois was dubious about the possibility of identifying objective criteria as either sacred or profane, and he rejected the utility of these categories for comparative social-scientific use. Others after Durkheim nevertheless promoted and extended the dichotomy, including influential scholars like Mircea Eliade, who even made it the centerpiece of his most popular work on the historical and comparative study of religion.[18]

"Adequate as this [sacred-profane dichotomy] may be for theological purposes," the English social anthropologist Jack Goody surmises, "it is hardly sufficient as an analytic tool of comparative sociology."[19] Despite the uncertainties and objections raised to theories of ritual that invoke polysemous notions like the sacred and contested categories like religion, ritual theory is an expansive field of inquiry, and a number of ritual theorists provide actionable insights about the motivations and consequences of people's behaviors. We need not rush, in other words, to abandon all theorization of ritual as an analytic category because of the social-scientific inadequacy of the sacred-profane dichotomy or the disputed nature of religion. Given the historical use of the term, the task of theorizing ritual from and

for a specific disciplinary outlook demands that we press on and take a critical view of academic understandings of religion and the religious, which notably since Durkheim's sociological paradigm have included ritual activity.

Although the incidence of ritual activity is commonly folded into the cultural institution of religion, in the Durkheimian system the mean-ends relationship of ritual is symbolic rather than intrinsic to the activity of ritual itself.[20] When a means-end relationship is intrinsic to an action, the means bring about the end, consistent with progressions that are valid according to scientific causation. Arguably more influential than Durkheim's theorization of ritual in this regard was the work of his nephew, Marcel Mauss, whose synthesis of "technique"—articulated with his uncle in *De quelques formes primitives de classification* (1901–02) and in his own studies, "Les techniques du corps" (1934) and *Manuel d'Ethnographie* (1947)—swayed anthropological and sociological deliberations on ritual in the first half of the twentieth century. Mauss pioneered the idea that "magic, sacrifice, sorcery, shamanistic practice and technical arts could be put together into a single category of 'techniques,'" Jean-Pierre Warnier argues, "because all of them have *tangible effects* that can be assessed and described."[21] In his own words, Mauss wrote: "I call technique a *traditional efficacious* act (and you can see that it is not different from the magical, religious or symbolic act). It has to be traditional and effective."[22] He insisted on this dual effect of techniques, and hence the dual effect of so-called religious acts: the latter are transmittable by tradition and they have substantial real-world effects.[23]

Mauss's painstaking and complex work on techniques and cultural technologies was eventually outstripped in the second half of the twentieth century by scholars working on the anthropology of technology like Robert Cresswell and François Sigaut, who raised materialistic questions and concerns about Mauss's views, and Durkheim's before him. Deploying Marxist readings of social forces on the technical work of tradesmen, agriculturalists, and artisans, the analyses of cultural technologies by Cresswell and Sigaut moved the consideration of ritual away from associations with religion.[24] They also repositioned their thinking about means-end relationships in ritual to reflect on targets of technologies, such as human subjects and lifeless matter. Annemarie Mol has advanced this work in the twenty-first century in subtle and fruitful ways. Her approach to explaining human behavior focuses neither on people's motivations nor the first person accounts they give about what they do. She prefers to study interventions, spaces and places where people and objects meet. Mol encourages us to stop trying to follow and know "a gaze that tries to see objects" and instead attempt to understand "objects while they are being enacted in practice. So, the emphasis shifts. Instead of the observer's eyes, the practitioner's hands become the focus of theorizing."[25]

It would be wrong to think that Mauss was completely unconcerned with ritual targets. But his way to approach that matter rested largely in the ways that people confirm efficacy in ritual, magic, sorcery, etc. For example, with Henri Hubert he

argued that the ends of ritual activity belong to a "world of ideas which imbues ritual movements and gestures with a special kind of effectiveness, quite different from their mechanical effectiveness." They then classified ritual acts and gestures as "*traditional actions whose effectiveness is sui generis*."[26] This delineation still leaves us with crucial and unanswered questions about adjudication. Who measures efficacy and by which criteria? Do the means of ritual (or magic or sorcery) produce this peculiar end consistent with progressions that are valid according to scientific causation? When the answer is no, the ritual practice is oftentimes taken to be irrational and/or ineffective.

Talcott Parsons nuanced the Durkheimian and Maussian descriptions of ritual when he argued that ritual acts are not symbolic of means-end relationships and that means-end relationships are not intrinsic to ritual practice. After refusing to link ritual activity to both of these things, he did not go on to say that ritual practices are irrational, as we might expect. Instead, Jack Goody explains, Parsons advanced the idea that ritual is a type of action that is "neither rational nor irrational . . . but non-rational, or 'transcendental'; that is, it has no pragmatic end other than the very performance of the acts themselves, and cannot therefore be said either to have achieved, or not to have achieved, such an end."[27] Parsons's suggestion that ritual acts are ends in themselves anticipated something Frits Staal argued two decades later regarding the Indian context, when he tried to debunk the view that rituals communicate symbolic meaning. "The only cultural value that rituals transmit are rituals," Staal provocatively asserted. Ritual, he continued, is "pure activity, without meaning or goal," existing entirely "for its own sake."[28] Staal's position received a fair amount of criticism. In two different pieces in the *Journal of Ritual Studies*, George Thompson and Solomon Harris each contended, contra Staal, that ritual does have symbolic meaning, and it is often meaning that points to sociohistorical value systems tied to the particular group performing the rituals.[29] These two scholars thought rituals communicate knowledge to the members of the in-group, which through ritual performance becomes a ritualized body. And the "rules of the ritual are," according to Harris,

> self-contained within that ritual and have no bearing on things outside that ritual. But the ritual as an entity is related to its associated group and the historico-social evolution of that group. . . . Thus rituals are embedded in the value system of their respective groups and serve the purpose of internalizing and perpetuating that value system, or some aspect of it. Looked at in this way, the internal rules of ritual *per se*, may in the restricted sense of 'meaning' as used by Staal, be regarded as meaningless; but the ritual as an entity and as a component of the socio-cultural value system of the particular group, is meaningful.[30]

The work of Talcott Parsons and counter-positions to Staal's postulation about the meaninglessness of ritual stress the social functions and value of ritual. Harris referred to this as the "we-ness" of ritual; below I call it ritual "sociality." It points

to a fortified awareness of or attentiveness to the group's activity, which I refer to as the ritual element of "cynosure." These positions did not declare ritual to be irrational or ineffective as such. Instead, they operationalize ritual as a multivalent analytical term with which to query individual and group activities apart from (or outside of) the domain of religion, in spite of the fact that so many scholars of ritual since the late nineteenth century have argued that the irrationality of ritual acts is what makes them religious. Nevertheless, even if ritual practice is deemed valuable in itself, and thus non-rational in Parsons's sense, his theory still relegates ritual to the actor's frame of reference, and this is problematic. For a ritual is non-rational, irrational, rational, or something else entirely depending on the perception of the observer, not the actor, whose analysis imputes a connection or gap between the means and the end of the activity.

By recognizing the value of the acts of rituals themselves, Parsons emphasized the practice and behavior of ritual activity and, though I am unsure about the degree to which he intended it, also the bodily basis of ritual. But he foregrounded belief and understanding in his analysis, calling to mind Evans-Pritchard's classic study of the Azande, and his useful warning that there has not been sufficient evidence to suggest people in non-western societies adhere to supposedly universal paradigms like the sacred and the profane. Evans-Pritchard distinguished between "ritual and empirical actions by reference to their objective results and the notions associated with them."[31] While I do not support Parsons's proposition, or the similar argument of Staal, that ritual acts have no pragmatic ends beyond their performance, I do want to draw attention to the bodily, performative, and especially the processual activity of ritual that Parsons's analysis highlights. But then I would press further. Ritual actions, as I conceive them, cultivate a kind of discipline in actors, creating "ritualized agents," as Catherine Bell puts it, whose bodies subtend an instinctive knowledge, certain ideals, and dispositions that enable the achievement of desired ends.[32]

In any theorization of ritual, it is vital to ask oneself how exactly the category is being used. Does ritual carry any implicit or explicit assumptions that such actions are causal social factors or organizing principles? Are rituals, in other words, existing processes for social actors or categories that exist primarily for researchers? My sense is that scholars working on ritual often fall prey to the former temptation—taking rituals as causal social factors, not organizing principles of the observer. This leads to the erroneous belief that rituals, because of an inherent symbolic or expressive force, illustrate major facets of social behavior rather than merely expressing or signifying social structures of the observer's view. This approach, to follow Goody, "simply involves the reification of an organizing abstraction into a causal factor."[33] William Sax christens this the "academic sin of reification," or mistaking an analytic category for a natural kind.[34] By taking ritual as a concrete or real expression of social behavior, many scholars, coasting in the wake of Radcliffe-Brown's theory, have defined ritual in opposition to rational and scientific acts.[35]

The symbolic force of ritual is assigned from outside, by the observer, ascribed to the actor, and imposingly declared to be integral to the actor's frame of reference in an attempt to make sense of what otherwise appears devoid of reason. Here again, as with questions of meaning, the matter of symbolic significance is fraught with ambiguity. For whom is it symbolic? For the actor, for the spectator, for both? If we proceed from the assumption that ritual is an analytic category of the observer, not an interior belief of the actor, we must then accept that the observer assigns meaning, expresses whatever aspects of ritual actions are symbolic of social structures, and so on, not the actor (who might or might not have knowledge of a symbol's reference, and very well could reject its interpretation when she learns it).

None of this is to say that social actors themselves never speak about ritual. In this chapter, and throughout this book, I am most interested to analyze scholars' intentions and conceptions when we deploy a category like ritual or exchange, or attempt to define a discipline like philology. All the same, it is important that we do not lose sight of the fact that social actors have their own ways to categorize ritual, knowledge, and exchange that might or might not accord with the categories we impose on them. The word ritual, in non-academic usage in the United States, for example, often immediately brings to mind associations with religion and psychology. People who claim to do ritual tasks (whether they are identified by scholars or not) might be aware that some of their actions are different than others and even have a different kind of, or an anticipated or hoped-for, efficacy. Fieldwork might even reveal to the researcher that so-called ritual actors are aware that their actions in certain instances are different than others, and indeed they might even use the term ritual to express this type of understanding or awareness. But from the researcher's point of view, the frame of reference through which the category of ritual is applied belongs to the researcher, and thus it exists apart from actors being observed. The researcher's perspective, including the reception of "ritual information" from actors in the field, is vital to acknowledge and explain. Otherwise, the presentation of ritual analysis will mean multiple things to multiple readers, and the scholar's handling of this analytic category runs the risk of appearing to be little more than a presentation of the actor's views, rather than his or her explanation and interpretation of observed events and behaviors.

Many of the activities at Shantimana and Mookkamangalam are remarkably similar to those described as rituals in religious studies literature. A major and unavoidable difference, however, is this: actors in the south Indian ayurvedic gurukula do not engage in activities that would appear to be oriented toward or linked to religion, divinities, or anything akin to the so-called sacred. Vaidyagurus and students at Mookkamangalam, for instance, see their clinical activity in no uncertain terms as medical science (*vaidyaśāstraṃ*, Mal.). They work with and dispense medicine to promote health and wellbeing. If we acknowledge that their work is devoid of a religious component, is it then reasonable to discuss their practices as rituals? Must we use terminology that evokes ritual theory, directly or indirectly, that draws comparisons to religion and the religious to understand and

describe the medicine and healing practices of vaidya-gurus in central Kerala? Can we instead accurately say that the actions of these healers fall within a category of ritual that is neither religious nor magical, that does not necessarily admit the presence of divine entities, and for which a means-end relationship is intrinsic (such as, therapeutic practices leading to health)?

RITUAL AND MEDICINE

In scholarly literature on the intersection of medicine with other cultural institutions, such as economics, politics, and especially religion, it is not hard to find descriptions of a visit to a doctor's office portrayed with terms that resemble jargon in ritual theory. An example in this vein that I often read with my students is John Welch's "Ritual in Western Medicine and Its Role in Placebo Healing." In this piece, Welch suggests many points of similarity between the acts of a doctor-patient encounter in a biomedical context and the acts he calls "the shaman's blend of religion and medicine."[36] Over several pages, his comparison unfolds like this: a sick person travels (Welch uses the verb pilgrimages) to the doctor's office, and upon entering the waiting room, he crosses a threshold from the mundane (profane) world into the marked off and special (sacred) space of healing. In the process of moving from a mundane to a special space, the journey (the noun pilgrimage) itself becomes significant in a way that distinguishes it from routine travel. Whether set up in advance as an appointment or because his sickness becomes so aggravating or dire that sudden medical attention is required, this type of travel focuses his attention on a specific destination and a pointed goal (mission), transforming the person from an ordinary civilian into a patient–qua–pilgrim. Welch adumbrates this journey in a way that most adults in the United States can easily recognize, culminating with unease and anticipation at the journey's terminus, the "temple of healing."[37] The patient–qua–pilgrim is received by receptionists and nurses (temple superintendents). They query him and produce an initial judgment of his condition, recording the details of their inquiry in their "book of life."[38]

Sometimes the transformation into patienthood is further solidified if the doctor's visit requires denuding from street clothes to an austere hospital gown. Fully clothed or now somewhat exposed, the patient waits for the doctor (temple priest or priestess), the healer who speaks to the sick and infirm on behalf of the "gods of medicine." These healers are celebrated for their access to seemingly transcendent knowledge about the human body and how it works, knowledge that's been passed on, tested, and expanded for centuries and is the foundation of the medicine patients desire.[39] Dressed in white robes, the doctor receive the patient's report of complaints just as a priest hears a confession. There's a "laying on of hands," sometimes using special instruments for looking into dark spaces and hearing fine sounds inside the patient's body.[40] The doctor-qua-priest then conveys portions of the healing knowledge of the medicine gods, knowledge that

characterizes his professional life and, for so many patients, is simultaneously confusing and anxiety-inducing. This knowledge in effect brings the doctor and patient together, and once it is shared it defines and gives meaning to the patient's experience of illness.

Welch qualifies the doctor's tools, texts, and language with the adjective "sacred," and therapies are comprised of ointments and pharmaceuticals "of unknown substances" that appear mystical to patients and may include a set of actions to be performed at home.[41] Whatever the therapy entails, he writes, it will include "a reiteration of our common beliefs concerning health and illness, how we believe we maintain order and balance between the two, and a promise that the therapeutics will result in a restoration of that health and a balance between ourselves and the cosmic forces of wellness."[42] Welch presents a colorful correspondence, bordering on the parodic, between a biomedical doctor-patient encounter and the priest/priestess-pilgrim engagement. His comparison is based on a study of the use of placebos in biomedicine, suggestive of Ted Kaptchuk's contention that "placebo studies may be one avenue to connect biology of healing with a social science of ritual. Both placebo and ritual effects are examples of how environmental cues and learning processes activate psychobiological mechanisms of healing."[43]

Environmental cues and processes of learning do play a role in the healing of patients generally speaking, and this is also true in the gurukulas of central Kerala. Unlike Welch's study, I want to ask what happens when we read medical practice using ritual theory *without recourse to religious discourse or imagery*. But if we eschew this language, do we have to drop ritual theory? Ronald Grimes memorably reminds us that when we raise questions about ritual in medical contexts, there's bound to be pushback and dismissiveness from practitioners. "Generally, priests think they are engaged in ritual," he quips, while "generally, physicians deny that they are."[44] A decision by priests or physicians to use or reject ritual as a term for what they do tends to signify the degree to which they see their work as efficacious. Priests are effective at what they do because they have rituals in their earthly positions to aid their communications with and on behalf of the divine. Physicians—especially, but not only, in biomedicine—deny a place for rituals in their work because they view medicine as utterly thisworldly, entirely human, and for them the association of rituals with the divine and religion is too deep-rooted to imagine ritual activity otherwise. Activities depending on transcendent communication or influence are unnecessary in the medical setting, if not irrational. RCTs are a pillar of biomedical research, and even though the doctor-patient meeting described by Welch contains emotionally supportive and trust-building features that benefit patients, also known as a doctor's "bedside manner," the interpersonal aspect of biomedicine is also critical to inspire obedience and prepare patients for the "real" medicine that will be prescribed later on. The ideology of biomedicine thus marginalizes ritual, alongside the placebo effect, where it is often classified as art rather than science.[45]

Biju and his students refer to clinical acts like *ūtu* that require on-the-spot preparation and delivery of medicine as *prayogaṃ*s (Mal., from Sanskrit *prayoga*). A *prayogaṃ* is a practice or application, a means to some end. It is juxtaposed to theorizing and the visualization of a plan, and it involves the coming together of a sequence of acts that collectively advance toward a goal. A clinical *prayogaṃ* occupies the latter half of gurukula philology that I described in chapter 2, and it requires adept technique and experience. Experience here includes deep knowledge of the Sanskrit and Malayalam literatures in which the actions to be performed are explained, as well as years of clinical appointments practicing those literatures with and for patients. Experience and good technique thus point to the repeated application, testing, and practice of texts. A seasoned vaidya-guru like Biju or Priyankara knows when and for whom to perform any given therapy established in the literature.

Daily activities in a gurukula clinic involve practices that can neatly fit within more than one scholarly definition of ritual. For instance, at times and to varying extents, elements of Stanley Tambiah's classic definition are evident, including ritual formality-conventionality, stereotypy-rigidity, and redundancy-repetition.[46] If we combine Bourdieusian practice theory with Tambiah's conceptual framework, it is also clear that the clinical care Biju routinely gives and the texts he trains his students to master include embodied practice undergirded by a logic that's irreducible to linguistic expression.[47] Special attention is also given to space, as Richard Schechner puts it, so that "the performance process and the ritual process . . . are strictly analogous."[48] From the participant-observer's standpoint, a somewhat problematic part of clinical meetings at Mookkamangalam and, earlier, at Shantimana involves what Thomas Csordas called the patient's internal states. It was often tricky to pin down the predisposition, empowerment, and transformation of Biju's patients, since most did not want to answer questions beyond the details of their immediate healthcare needs.[49] The information I was able to obtain about patient perspectives, feelings, and experiences of illness mostly came from Biju and his students, for whom this kind of information emerged organically in small talk and especially with patients and attendants whom they knew personally.

The features that scholars choose to emphasize in definitions of ritual point to the variety of ways that rituals may be framed to convey the "sense of 'This is a ritual,'" as Stewart and Strathern explain it.[50] The three ritual foci I present below—sociality, reformation, and cynosure—contribute to a working definition of ritual in the way that Jan Snoek suggests most definitions produce a "fuzzy set" or "polythetic class" of common characteristics.[51] We know a practice fits within the category when it resembles the definition's components, and practices will align more or less with the components, though probably not perfectly. In effect, when you see it, you know it, à la Wittgenstein's family resemblance (*Familienähnlichkeit*) approach to analytic categories: though we recognize that what we are calling rituals are not all the same, we also acknowledge that rituals share certain

characteristics and, to agree with William Sax about the fuzziness endemic to ritual theory, "when a particular activity has a sufficient number of them, it 'counts' as ritual, more or less."[52]

Before probing the case of *ūtu*, I want to mention a small but important methodological point. My aim here is to explicate a basic theoretical model to analyze ethnographic data I have gathered among ayurvedic physicians in central Kerala over the first two decades of the twenty-first century. I hope to capture the *processual* components of ritual *formation* and *activity* through which behavior patterns are both modified and serve communicative functions apart from their primary or original functions. In short, my aim is to theorize, following Irenaus Eibl-Eibesfeldt's classic expression, the process of *ritualization*.[53] Consequently, most phenomenological reflections on *ūtu* in the patient's experience (Csordas's so-called internal states) are bracketed. Patient experience is important, no doubt. The patient is always there, and without the patient, neither the ethnography nor the theorizing in this book could happen. Although I do consider the involvement and placement of patients in *ūtu*, I do not delve into their feelings. In the next chapter, the patient in Ayurveda and in medicine in general, apropos the idea of wellbeing and ayurvedic healing, occupies part of my closing reflections.

THE CONTEXT OF BLOWING THERAPY: *ŪTU*

Ūtu, blowing therapy, is not described in Ayurveda's Sanskrit classics. The textual reference Bhaskaran, Priyankara, and Biju rely on for this therapy is the late medieval Manipravalam text, the *Jyōtsnikā*. Cherukulappurath Krishnan Namboodiri draws on this text and offers a very similar account of blowing therapy in his modern Sanskrit work, the *Viṣavaidyasārasamuccaya* (*Precious Compendium of Poison Treatment*). Both texts advise physicians to perform blowing therapy when presented with snakebite victims who exhibit symptoms like delayed responses to verbal and physical stimuli, drowsiness, numbness of the tongue, vertigo, body aches, and excessive salivation. The two descriptions of which plants to use during the procedure and how to perform it are not extensive in either text. C.K. Namboodiri's Sanskrit text has the following two *śloka*s, where the key therapeutic act is marked by the onomatopoetic noun of agency, *phūtkāra* ("making a puffing sound" or "blowing"), connected to the verb *kṛ* ("to do" or "to make"):

> After taking equal amounts of dry ginger, stinging nettle, black pepper, and Indian birthwort in the mouth [and then chewing], at the same time they should blow continuously and slowly 50 times [each] into the two ears and onto the top of the head of the person who is bitten. This should obstruct the poison from going beyond the body's three constitutive elements [*rasa, rakta*, and *māṃsa*], the skin, etc.

The *Jyōtsnikā's* statement is similar:

> Add up equal parts of dry ginger, stinging nettle, black pepper, and Indian birthwort. Give [the plants] to the three of them to chew. [Have them] blow into the two ears and

> onto the top of the head [of the snakebite victim] correspondingly, counting up to 150 [breaths]. The poison will disappear quickly from the three constitutive elements.[54]

As descriptive as these passage are, they do raise some questions, especially concerning the labor of *ūtu*. Who chews the plants and blows into the patient's ears and onto his head? The *Jyōtsnikā's* reference to "the three of them" is surely a clue, as is the use of the third person plural optative (*parasmaipada*), "they should blow," in the *Viṣavaidyasārasamuccaya*. I learned in 2009 that the vaidya-gurus at Mookkamangalam do not blow the medicine on the patient themselves, and as we will see in a moment, this crucial task falls to the attendants who bring the patient to the clinic. Biju and Priyankara are less hands-on during the procedure than these friends and family who, in this particular emergency situation, are essential to increase the snakebite victim's chances of survival. I will return to this perhaps counterintuitive aspect of *ūtu*—that medically untrained people rather than an experienced physician assume such an important role—and in the next chapter, I explore the nature of the "attendant" (*upasthātṛ*) in relation to the rogin in classical *āyurveda*. The accounts of *ūtu* in the *Viṣavaidyasārasamuccaya* and *Jyōtsnikā* also offer little obvious information about procedural rationale or *ūtu's* basis in ayurvedic theory, though there are some clues about the ways this therapeutic breathing is connected to the classics by theories of the body's "constitutive elements" (*dhātu*s), "vulnerable spots" (*marman*s), and "humors" (*doṣa*s).

In their introduction to the *Viṣavaidyasārasamuccaya*, U.M.T. Brahmadathan Namboodiri and Madhu K.P. explain that despite not being mentioned in the collections of Caraka, Suśruta, and Vāgbhaṭa, *ūtu* has been practiced in south India for ages and to do it properly, one needs the guidance of an experienced guru and deep understanding of ayurvedic theory. Without this kind of training a physician wouldn't know that *ūtu* is only effective when indications of envenomation manifest in the first three of the body's seven *dhātu*s, "constitutive elements"—*rasa* ("chyle"), *rakta* ("blood"), and *māṃsa* ("flesh"). "So, a proper study of Ayurveda is needed," they contend, to practice this specialized and regional therapeutic modality.[55] A physician properly trained in classical *āyurveda* would also have knowledge of the body's vulnerable spots, *marman*s, and the action of the "wind humor," *vāta doṣa,* in someone who has been bitten by a venomous animal (C.K. Namboodiri mentions snakes, spiders, rats, scorpions, and others) or interacted with a poisonous plant or mineral. The *marman*s are linked to the vascular system (e.g., heart, arteries, veins, and capillaries), tendons, channels of the nervous system (e.g., the spine), and particularly the head, the *mahāmarman* or "great vulnerable spot." When a *marman* is injured, *vāta doṣa* in its vicinity becomes agitated and moves to areas where its undue presence generates illness and potentially death.[56] The fundamental meaning of *doṣa* is "fault" or "taint."[57] Collectively, the three *doṣa*s — *vāta* ("wind"), *pitta* ("bile"), and *kapha* ("phlegm") — are the body's pathogenic arbiters, and as venom matures in the body *vāta-doṣa* is especially likely to inflame. Its complex makeup and movements are thus crucial for the physician to assess and control.

Kenneth Zysk has written about *vāta doṣa* in Sanskrit literature, going back to the *Ṛgveda* and Upaniṣads and, important for us, in the big trio of Sanskrit medical classics. His research shows that *vāta* is subdivided into five vital breaths or winds, sometimes known in different textual traditions as the *pañca vāyu*s or *pañca prāṇa*s:

fore-breath (*prāṇa*)
up-breath (*udāna*)
middle-breath (*samāna*)
intra-breath (*vyāna*)
down-breath (*apāna*)[58]

Each text has slight variations about the locations and functions of the the five vital winds in the body: *prāṇa* is unanimously located in the head or mouth, and from there the others are ascribed to places in the body below the neck, ending with *apāna* in the anal-rectal region. Properly calibrated *vāta* facilitates bodily movement, ensures mental acuity and proper breathing, and aids expulsion of waste from the body through spitting, sneezing, sweating, expectoration, urination, and excretion. When the five winds are impeded or irregular, physical debility, pain, and sometimes death can ensue.[59] A person might experience death, moreover, as a result of an occlusion of the five-part *vāta doṣa*'s natural movement in the body.[60] The two textual attestations of blowing therapy visibly involve the movement of winds from sources external to an ailing body into/onto an ailing body, the successful performance of which will pacify the five-part *vāta doṣa* in the patient suffering from poison toxicity.

Four verses after his statement on this unique Keralan *viṣa* treatment, C.K. Namboodiri describes another method for calming and regulating *vāta doṣa* aggravated by poison, though here the external source of manipulation doesn't involve blowing medicine but a vaidya's physical suppression of the patient's breathing by tightly squeezing his nose and mouth and periodically encouraging him to inhale medicinal odors. In this procedure, a vaidya smears the ripened leaves of the *arka* (milkweed) and *hiṅgu* (asafoetida) plants on her hands, and presses them tightly over the nose and mouth of the patient, briefly interrupting the patient's breathing. The vaidya removes her hands after a moment, allowing the patient to catch his breath and inhale the medicinal scent of the leaves, and then repeats this procedure three times.[61] This practice, on its own or as a complement to blowing therapy, V.M.C.S. Namboodiri explains, temporarily shuts down the path of the patient's five winds (*vāyumārga*), causing them to move in new directions. This has the effect of opening up the "subtle and infinitesimal channels" (*sūkṣmātisukṣma srotas*) in the envenomed patient's body, and when the vaidya removes her hands and the patient inhales deeply to catch his breath, the medicine of the *arka* and *hiṅgu* leaves is easily absorbed into the body.[62]

The case of *ūtu* therapy presents a good example of the application of ayurvedic theory in the clinical space of the south Indian gurukula. Its design targets the key

bodily component attacked by snake venom (and other animal and plant poisons), the head, which is the primary seat of *vāta* and a person's most vulnerable spot.[63] Botanical remedies a gurukula vaidya instructs a patient's attendants to chew and blow onto the patient have an acute antidotal effect (*viṣahara*). As we saw, there are four herbs:

dry ginger (*viśva*)
stinging nettle (*dusparśa*)
black pepper (*marica*)
Indian birthwort (*viṣavega*)

These plants have a "sharp" or "fiery" quality (*tīkṣṇa*) that protects, soothes, and purifies the critical spots of the ears and highpoint of the head (*mūrdhan*). The deliveries of the plants' healing potency through breathing, Biju explained to me, is supposed to quickly vitiate the spread of the poison, while the measured blowing treatment is meant to recalibrate the patient's aggravated vital breaths.

RITUAL PRACTICE: COMPONENTS OF HEALING ACTIVITY

The connection between the theory and the practice of *ūtu* underscores the intrinsic means-end nature of the procedure, crucial to theories of ritual going back to Durkheim, and is a well-defined example of the practice of texts. The means of preparing four plants and administering them with controlled breathing are intended to bring about specific ends. The survival of the envenomed patient is the first and foremost goal, while mitigation of the poison in the patient's body is the second. Third, by ensuring survival, the patient gets a chance to cultivate a long and productive life, which ties *ūtu* to the overall aim of Ayurveda, practicing textual knowledge for the wellbeing of those who need it. The means-end relationship of *ūtu* is based on both the physician's experience and her mastery of textually attested theory. The success of her organization and management of *ūtu* rests on what Lévi-Strauss called "symbolic efficacy," insofar as she empowers the people gathered together with a sense of trust that she, the vaidya, can ably attend to this troubling situation with adroit execution.[64] What's more, J.Z. Smith's observation that ritual "gains its force where incongruency is perceived" applies to the vaidya's performance of *ūtu*, too.[65] The incongruence of a damaged human condition with the ideals of classical *āyurveda* powerfully illustrates the "broken and ambivalent nature of our world," recalling Seligman *et al*, and the attempt to cope with, if not to fix, that disagreement is at the center of the healing enterprise as much as it is a major function of ritual in general. Ritual practice, just as medical practice, Smith further explains, "is a means of performing the way things ought to be in conscious tension to the way things are."[66] Rituals are vital because, in reality, the ideal—the way things ought to be—cannot be realized perfectly or perpetually. In this way, medical acts are ritualistic when they work on the gap between ought

and is, when they attempt, Kaja Finkler posits, to resolve the physical and abstract "contradictions in which patients are enmeshed" by illness and impairment of all kinds.[67] These acts can be ritualized to varying degrees depending on the extent to which they work on the is-ought inconsistency. Where do we see this mitigatory function at work in medical and healing contexts? Using *ūtu* as the lens through which to see the clinic and bodily healing as fields of and for ritual action, I submit that the following three features are essential to arrive at an understanding of ritual as a actionable analytic across cultures and cultural institutions: sociality, reformation, and cynosure.

Sociality: A collection of people must come together to perform *ūtu*. In addition to physician and patient, the people who bring an envenomed patient for treatment are critical to the success of the procedure. Whether they know it or not in advance (most do not), these attendants directly impact the outcome of the patient's treatment. Once they arrive at Mookkamangalam, they become ritual instruments of the physician. Biju explained the details of the practice to me in 2009 the morning after the first of the two *ūtu* performances that occurred during my research in central Kerala. I was in the state for just two months of fieldwork that year, and this case occurred while I was on a train back to Thrissur from Thiruvananthapuram, where I'd been for a few days visiting the Government Ayurveda College and Ojaayit, whom I had met at the college five years earlier and who was opening his own clinic in the city with his wife, who practiced ayurvedic OBGYN. Biju could see that I was disappointed to have missed this patient's arrival at his clinic. I had heard about *ūtu* from him and his mother, as well as from Dr. Matsuzaka, who had been visiting Mookkamangalam for years before my project began. So, he tried to describe the event to me as carefully as possible, and even if it wasn't the same as being there, his account and the textual precedents I considered above provide ample data to illustrate the social component of the procedure.

Biju said he typically requires three people to assist him when treating a patient with *ūtu*. "Usually, two people blow *auṣadhaṃ* into the ears of the patient and another blows it onto the top of the patient's head." But as it had happened the previous night, I learned that *ūtu* can be performed with two attendants. The helpers are sometimes members of a patient's family, though that is not a requirement. Biju continued, "the helpers should not have consumed alcohol or eaten spicy food [in twenty-four hours] prior to treatment; these are *tīkṣṇa* and may blend with the *auṣadhaṃ*, rising the [already fiery] qualities of the herbs that are chewed and blown on the patient's head. This can cause more harm and counteract healing."[68]

As my luck would have it, three days after the first incident, and three or four hours after I had left the gurukula and returned to my room for the night, another collection of people arrived at Mookkamangalam, with another snakebite victim whom Biju and Priyankara determined required *ūtu* therapy. Though after learning about this second incident I felt very unlucky (again!) that I wasn't on site to

see this south Indian therapy in action, Biju and Priyankara reminded me that these cases often occur late at night, when snakes are active and harder to see in one's path. I never slept at their *mana*, and so, at the very least, these two events (and certainly others) drove home the realization that sometimes (even oftentimes) participant-observation can be an unpredictable method of data collection. Once again, as I was there the day after, Biju and Priyankara graciously did their best to offer detailed information from the night before.

While in the first case the patient was an adult woman, the second patient was an adult man. The female patient's two attendants were a man, who blew into one of her ears, and a woman, who alternatingly blew onto the top of her head and into her other ear. The male patient had three attendants, all men, and each attended to a single location. In both cases, the patients arrived very soon after being bitten. Both also survived following *ūtu*. Neither group had been able to report the type of snake that bit their respective patients. I asked Biju and Priyankara if this lack of information impacts their choice of treatment. It does not, Priyankara told me, adding that "this is common." The vaidyas proceed apace when snakebite patients arrive at their *mana* by evaluating the symptoms. If a patient displays any symptoms of envenomation enumerated in the texts (e.g., lethargic response to verbal and physical stimuli, drowsiness, numbness, etc.), they begin therapy under the assumption that the case could be lethal. Given the different makeup of patients and attendants in the two groups, I asked Priyankara about the significance of gender during *ūtu*. "That does not matter. The main priority is quick treatment," she answered, "using available resources. Men-women interactions do not affect the *prayogaṃ*."[69]

Visits to ayurvedic physicians in central Kerala—whether traditional vaidya-gurus like Biju or state-licensed physicians at ayurvedic hospitals and clinics—are often collective events. To perform *ūtu*, a small group is necessary. The male patient was semi-conscious when he arrived at Mookkamangalam and could not have travelled on his own. But whether they are ambulatory or not, patients rarely go to Mookkamangalam unaccompanied, irrespective of their illnesses, and the patient's companions play key roles in Biju's and Priyankara's diagnoses. To collect information about a patient's condition and history, whenever I observed them, they often did not talk with patients until after they questioned the attendants. The people accompanying patients to Mookkamangalam clinic were rarely enlisted to participate in the application of medicine, as happened during *ūtu*, unless the patients were infants, small children, or unable to follow prescriptions on their own. The basic function of a patient's companion is to provide physical and emotional support and to contextualize and communicate health problems, commonly in addition to what patients offer themselves, and sometimes for patients who can't articulate these issues themselves because, for example, they are too young to express what they're experiencing, too sick to give a sober assessment of what they're feeling, or perhaps too anxious about meeting with physicians.

Priyankara and Biju usually gave patients a cursory glance during conversations with their escorts. But each new patient's background—including things like age, individual and family health history, domestic living environment, and so on—was gathered, as a matter of course, from the patient's escorts. These men and women offered their takes on the ailment that prompted their visit, whether it has improved or worsened, why it might have occurred, and any prior attempts to treat it. As we have seen, in the typical exchange at Mookkamangalam medicines are not dispensed, and Biju, Priyankara, or one of their students creates a *kuṟippaṭi* listing medicinal herbs for purchase and instructions about how to prepare the ingredients into a tonic, oil, or paste (*kaṣāya, taila,* or *cūrṇa*). It also outlines a daily, weekly, and/or monthly dosage protocol to follow.

In emergency situations requiring a procedure like *ūtu*, however, medicines must be dispensed immediately on-site. The body of the patient quickly becomes the focus of social orchestration under a physician's guided practice of texts. Plants are retrieved from the yard or from the premade drugs in the dispensary cabinet. Medicines are prepared for use, and the physician instructs the patient's attendants to chew the plants, following the instructions in the literature. I was told that if any of their students happened to be present, they might help position the attendants around the patient. Then Biju and Priyankara direct the helpers to blow the medicine onto the patient. Actors, objects, and actions come together because of an incongruence in their social nexus and interrelatedness, disrupting, as Victor Turner labeled it, their *communitas*. Ritual activity in this instance is "a matter of giving recognition to an essential and generic human bond, without which there could be *no* society," and trying to fix the broken social links.[70] The arrival of a snakebite victim at Mookkamangalam points to a divergence between the *socially real* situation of a person possibly dying from poisoning and the *socially ideal* state of somatic health expressed in theories of the body's *dhātu*s, *doṣa*s, *marman*s, and *vāyu*s.[71] The patient's ailing status jumbles familiar assemblies of social order and hierarchy that are, Turner noted, "rooted in the past and [extend] into the future through language, law, and custom." Rituals are therefore initiated in the absence and disruption of assemblies.[72] The urgency of a situation might demand that socially corrective actions are taken, actions that have, further to Turner's vision, the "spontaneous, immediate, concrete nature of *communitas*, as opposed to the norm-governed, institutionalized, abstract nature of social structure." The sociality of ritual "is made evident or accessible, so to speak, only through its juxtaposition to, or hybridization with, aspects of social structure" that existed in the community with which the patient is associated.[73]

During *ūtu*, the vaidya acts like a concert conductor. His role is directive and heuristic. Biju explained to me that when he oversees blowing therapy, he always observes and mentally classifies the relationships existing in the social scheme of the clinic.[74] The healing he's ultimately able to do can have a socially re-integrative function in this context, since the attendants engage in a sympathetic meeting

with the suffering patient, underscoring the import of communal sharing and acceptance of the suffering their group member experiences. In the course of *ūtu*, as Howard Brody observes of rituals at large, "a healing ritual becomes a bodily enactment of reconnection with the community."[75] Moreover, the medical ritual in this way can "gradually transform the [patient's] existence," Kaja Finkler argues, by "incorporating him or her, and sometimes the entire family, into . . . new interpersonal networks."[76] Transformation of a patient's social life has the capacity to restore *communitas* and in turn impact a patient's individual health.

Reformation: The reformative characteristic of ritual follows and overlaps with sociality. In the late 1970s Moore and Myerhoff made the case that social rituals are by definition organized events, with beginnings and ends, that bring together people and engender social reorganization. That is ritual's "dominant mode," they argued, echoing Durkheim's expression of the social. This coming together "is often quite exaggeratedly precise. Its order is often the very thing which sets it apart" from other, more mundane activities.[77] Among those involved in *ūtu*, the patient at once embodies and produces individual and social imbalance and disorder in the group. The eventual healing of patients remedies not only their particular health problems, therefore, but it also restores the units of family and friends who are actively interested in their wellbeing and shaken about the future abilities of the patients to participate emotionally and physically in their social networks.

Years later when Biju and I spoke about the nearly back-to-back *ūtu* cases in 2009, he told me that traditionally trained vaidyas like him usually only advise blowing therapy to pacify the symptoms of snakebite when it appears that venom is in the first three stages of maturation. He cited the *Suśrutasaṃhitā* to justify the approach, giving me what I later learned is a pat textbook method he teaches his students. The compilers of the text specify that in the first three stages venom usually has not yet settled in the victim's abdomen, where poison severely disrupts the *kapha doṣa* and the digestive system, leading to a potentially uncurable end. In the first stage, it infiltrates the blood, turning it black, after which, in the second stage, blackish skin begins to appear, and then, in the third stage, it penetrates a body's fatty tissues.[78] While that is what the literature says, and Biju admits that it is much harder to counteract snake venom after it has suffused the body's adipose tissue, in practice, he flatly put it, "we do *ūtu* on patients with almost all advanced symptoms, even on patients in semi-conscious states."[79] He added that sometimes it is difficult to identify and determine the precise stage of venom maturation in someone's body and it is in everyone's best interest to proceed with the most effective and quickest-acting treatment available, which at Mookkamangalam is often blowing therapy.

Overseeing an assembly of people gathered at their clinic to perform *ūtu*, Biju and Priyankara pay special attention to the attendants' blowing. They want to make sure they are blowing at a consistent speed, with an uninterrupted frequency of breaths, and that the blowing continues until the patient's symptoms

noticeably diminish or abate. From preparation to delivery of the four herbs, the procedure can last from as little as thirty minutes to over an hour. In the two cases I mentioned above, blowing lasted approximately forty minutes for the woman and almost an hour for the man. The condition of the patient upon arrival and the degree of help that the attendants can offer are key factors in the duration of this procedure. Since the combined target of the medicinal ingredients and their precise delivery is the relief of symptoms and ultimately the reformation of a person's physiological state, the constitutive parts and actions of *ūtu* function as a restorative ritual, to borrow Howard Brody's phrase. The performance of blowing therapy attempts to move a person from discernable states of social discord and physiological disorder to reformed states of social accord and order.[80]

Cynosure: Ritual acts point to and impose special meaning on otherwise ordinary things. They impart significance to things, and then those things command attention. As an observer, when I apply the adjective ritual to objects, acts, and actors, I am signaling their significance. I am not attributing substance. To construct definitions of ritual, scholars often suggest that these special actions carry weight because of what they represent, such as models of the body, social constructions, inversions of authority, and so on. On account of such significance, rituals warrant attention and special interest. We typically would not, for example, look at the dry ginger used in *ūtu* as substantively different before and after it's been masticated and blown into the ears and onto the head of a snakebite patient. But when it is pulverized into a medicine with Indian birthwort, black pepper and stinging nettle, manipulated by a group of people under the supervision of a gurukula physician trained in poison therapy, then repeatedly blown on a patient, the herbs become part of a social process that commands a new attention to its various parts. Collectively, the herbs become a fierce brew that palliates the wind humor (*vāta doṣa*) in the head and throughout the subtle channels of the patient's body. The people, too—physician, patient, and attendants—assume special forms and functions: respectively, conductor of medicinal preparations and healing performance; cynosural topography for the healing implementation of textual knowledge and botanical remedies; and therapeutic applicators (literal respirators!). The act of breathing becomes a process of moving curative winds from healthy bodies into an envenomed and unhealthy body. *Ūtu* also commands a new attention to the environment in which the practice unfolds. For the extent of the blowing therapy, there is a flow of affiliation between physician, patient, and attendants, streaming in vocal commands and herbal winds from a collection of bodies into and onto one body in order to prevent the departure of the ailing body's five vital breaths, and hence preventing its death.

J.Z. Smith wrote that ritual is "a mode of paying attention" and "a process for marking interest."[81] For him, the characteristic of attention directly counters claims of Protestant reformers in the sixteenth through eighteenth centuries who asserted that rituals were empty and devoid of thoughtful intention, more

like habits marked by repeated performance and lack of forethought. It is common to find references to repetition in definitions of ritual. And though the textual accounts of *ūtu* advise attendants to blow medicine onto a patient up to 150 times, Biju claims the precise number is immaterial. What's important is that the symptoms of the poisoning subside or disappear; if either result occurs after 60 or 80 breaths, that is enough. The exact performance of *ūtu* is thus always different according to the needs of each patient. It is never done with 150 breaths as a strict yardstick, despite what the texts say. The precise number of breaths has little value, in fact: too few, just as with too many, can be deleterious to a patient's recovery, and the vaidya has to scrutinize the practice of the attendants and the recovery or loss of health in the patient, moving the procedure onward or calling it quits accordingly.[82]

The characteristic of marking interest also highlights the essential role of place in ritual. If for Moore and Myerhoff the re-forming that ritual activity generates sets it apart from other types of activity, place, J.Z. Smith said, "directs attention."[83] Ritual environments are specially marked-off areas where everything is positioned for explicit reasons, where everyone acts according to certain formulas, and all things (and some people) require undivided attention. If place directs attention, then things (and some people) within the confines of the marked-off places—ritual objects and actors—become special by virtue of simply being present. That which makes them special and more significant than if they were elsewhere is the attention directed at them, attention that is demanded on account of their emplacement. For Smith and others (all of whom are indebted to Durkheim), that which makes ritual objects and actors special is often referred to as "sacred." But for Smith, "the ritual is not an expression of or a response to 'the Sacred'; rather, something or someone is made sacred by ritual."[84] The sacredness of objects and people in the course of ritual activity derives from their emplacement, in other words. There is no inherent difference between these people and objects when they are busy in a ritual environment, such as a temple, mosque, or church, as opposed to when they are outside of those places. When they are inside a mosque or a temple, however, the attention they receive makes them special and extra-ordinary.

With these components in place, we can then ask: Do the people and the objects involved in *ūtu* become special or extra-ordinary by virtue of following the reasoning and directions of the vaidya's orchestration and their emplacement at Mookkamangalam clinic? The answer is both yes and no. Their participation in the procedure makes them extra-ordinary in the sense that they become ritualized agents who, because of their performance, demand special attention. The collective actions of the group disrupt normal experience, and under the careful guidance of an expert, each person enacts what Richard Schechner called "hyper-experience." This experience is not abstract or merely a matter of academic conjecture, but "is made of definite sensuous items to do, smell, hear, see, and touch." *Ūtu* illustrates Schechner's perceptive observation that "more than any other kind of art or

entertainment, ritual is synaesthesis" and that "there is also a corresponding set of skills known to the ritualists for operating the performances."[85] The so-called specialists at Mookkamangalam and Shantimana are the vaidyas. The attendants too become ritualists of a sort in the course of *ūtu*, acquiring certain skills in the therapy of blowing. They do not possess the knowledge to establish and direct the ritual setting, however, as Biju and his mother do, and they require the ritual specialists' instruction to undergo this transformation.

In spite of the transformative capacity of *ūtu* for everyone involved, I would not follow Smith's theorizing further than I have already, and suggest that *ūtu*, of necessity, makes the people and objects involved somehow sacred. Instead of getting caught in the secular-sacred dichotomy when the question of ritual activity is raised, and thus forever holding the work of physicians and priests at odds (recall Grimes's quote earlier), what is needed is a narrower activity-based or practice-oriented lens to identify and analyze ritual. As an observer of medical practices, to pose the question—Is there, or can there be, ritual in medicine?—is not to inquire about the presence of, or reliance on, transcendent entities in a person's or group's performance. That might be present for the doctor just as we might expect it to be for the priest. The point is that both professionals may be said to perform rituals, given certain characteristics like the ones I just sketched vis-à-vis *ūtu*. So, yes, the short answer is that there can be rituals in medicine. We might extrapolate from the analysis of the qualities of sociality, reformation, and cynosure in *ūtu* to systems of medicine other than Ayurveda, such as Unani, traditional Chinese medicine, and even biomedicine, as well as to other cultural domains like education, politics, and religion. The flexibility of the components in the definition is critical. There will be different kinds of rituals and also different degrees of ritualization. With an analytic framework in place, ritual is potentially identifiable in many areas and institutions of human society and culture.

But we can still be more precise. Within the categories of sociality, reformation, and cynosure, there are also types of ritual action to further distinguish and analyze. In particular, a distinction of action types may be drawn between ritual rehearsal and ritual presentation. I deliberately draw these types of ritual activity from performance studies. They are meant to evoke the theatre in the sense that, for the observing ethnographer, the act of theorizing ritual in any context is necessarily an act of witnessing and commentating on the staging of a spectacle, in the fundamental sense of a specially prepared and arranged display.[86]

Ritual rehearsal is a practice marked by the process of returning to something again and again, not on one's own, but at the prompt of directives that have been heard or read. Moore and Myerhoff called this ritual acting: "a basic quality of ritual being that it is not an essentially spontaneous activity, but rather most, if not all of it is self-consciously 'acted' like a part in a play. . . . [It] usually involves doing something, not only saying or thinking something."[87] A ritual rehearsal is an action performed by people who do not have, think they have, or care to have

the requisite knowledge or capacities to achieve the goals of their practice without guidance. Success depends on someone or something external to the actor, like a director or a screenplay. An example of a ritual rehearsal could be prayer, since prayer usually depends on appeals to entities beyond the control of the actor (God, Allah, Viṣṇu, Ahura Mazdā, and the like) for a certain result. Caroline Humphrey and James Laidlaw discuss this in terms of "guided" action and "ritual commitment" on the part of the actor.[88] Similarly, the involvement of most medical patients in their treatments, whether in the preparation and/or taking of prescribed medications, falls within the category of ritual rehearsal. Patients play vital parts in their recoveries. But their capacity to be cured is contingent on the expertise and work of others well beyond their circle of influence, including the physicians who make diagnoses and prescribe medicines, as well as the manufacturers of the drugs they consume.

A ritual presentation, on the other hand, is marked by actors' awareness that they possess the competence to accomplish what they set out to do. Ritual presenters know they have the requisite knowledge and capabilities to accomplish their desired goals. Ritual presentations are done by skilled people. They are trained to execute highly specialized actions, and their training guarantees effective outcomes, which are measured against defined standards established in things such as canons of literature. Facets of *ūtu* fit neatly within this category as well as ritual rehearsal. A vaidya's recommendation and direction of blowing medicinal herbs is a ritual *presentation*. It is predicated on tested theories, observed data about human physiology, and years of clinical experience. His role as director of a group is evocative of a director's staging in the theater. Crucial to *ūtu's* success is his capacity to generate in the actors "at least an attentive state of mind, and often an even greater commitment of some kind . . . through manipulations of symbols and sensory stimuli . . . and through highly structured, rule-bounded activities, both of which produce concentration so extreme that there is a loss of self-consciousness, and a feeling of 'flow.'"[89] The work of an *ūtu* patient's attendants, in comparison, is an example of ritual *rehearsal*. Following Catherine Bell's description of ritual agents, during blowing therapy these attendants "do not see how they have created the environment that is impressing itself on them but assume, simply in how things are done, that forces beyond the immediate situation are shaping the environment and its activities in fundamental ways."[90] The so-called forces in this case are the healing properties of *auṣadhaṃ*, the vaidya's expertise in *āyurveda*, and the support derived from the group gathered together in search of reforming their *communitas*.

Another important way to discuss what's happening during *ūtu* is to analyze it in view of *ritualization*. The central virtue of this concept is its accentuation of the ongoing process inherent to ritual and the movement of a person's or a collective's performance to communicate something that stands beyond individual actors. Using the theoretical lens of ritualization allows us to stress the dynamic

and generative nature of ritual agency and activity. Mary and Max Gluckman used ritualization to refer to the acting out of social relationships to express and alter a given situation, usually a conflict, for the purpose of achieving material ends.[91] Keeping with their line of thinking, we can see *ūtu* as a medical ritualization involving a group of people whose interactions express and attempt to correct the conflict of illness. Ritualization in this view clearly encompasses sociality and reformation. Bell's analysis of ritualization further adds the component of cynosure. "Intrinsic to ritualization," she observes, "are strategies for differentiating itself—to various degrees and in various ways—from other ways of acting within any particular culture. At a basic level, ritualization is the production of this differentiation."[92] According to a practice-oriented analysis, *ūtu* highlights the distinction between the envenomed physiology of a patient and an ideal physiology outlined in texts on *āyurveda*, which the attending cohort of the patient aims to reify by becoming instruments of the vaidya's practice of those texts. By having the family and/or friends of patients both draw attention to, and attempt to counteract, the course of venom in the bodies of people who've been bitten by venomous snakes, *ūtu* compels social reciprocity and the correction of collective incongruence.

Seen as ritualization, *ūtu* is not a series of acts that renders sacred the whole therapeutic process. Yet the process is still made different through strategic means.[93] The decisive punctuation in ritualization is the condition that sets apart, begs attention, and gives special significance to the ritual process. This is the aspect of cynosure. The category of ritualization is interrelated across the three features of ritual I have presented in this chapter, and it conveys the understanding that ritual is always active and always entails development of some kind, positively or negatively. The social and reformative aspects help to generate the cynosural attention that ritual eventually demands.

By applying a practice-oriented approach to the study of ritual, we avoid reading into *ūtu* merely what we want to know and imposing conceptions and beliefs onto actors' frames of reference.[94] By looking to the "methods, traditions and strategies of 'ritualization'" we do not discuss ritual and ritualization in universal terms or along the lines of binaries like sacred-profane and religious-secular, or even religion-medicine, which often constrain analyses and skew conclusions.[95] Instead, a case-by-case analyses of practice—in *ūtu*, the vaidya's practice of texts to coordinate healing plants, a patient's body, and human respirators—speaks to how certain experts and a community can come together to attend to situations of incongruity (emergencies, illnesses, poisoning of various kinds). The idiom of ritual theory can be helpful to explain the events of the south Indian healing practice of *ūtu*. The language used needn't carry an unstated or stated association with any particular domain of human culture. The features of sociality, reformation, and cynosure can apply to a medical context as well as a religious or economic context. We may use these categories in various places, too, and ask if ritual activity exists in the classrooms of higher education in the United States or in the halls of

European political institutions. The foregoing scrutiny of *ūtu* as a ritual activity suggests that the ritualist and the medical doctor do not have to see their work as incommensurate at the level of performance. The gulf separating the ritualist and the healer with which the chapter began can be dissolved, in no small measure by carefully identifying what the term ritual is meant to do when it is deployed and by purging the language used to describe ritual activity of assumptions that it naturally belongs to one segment of culture over another.

When Biju and Priyankara practice poison treatment texts to perform an emergency procedure like *ūtu*, we can see that at the level of performance their practices are, fundamentally, ritualistic in the same way that scholars of religion might be inclined to describe the agency and activities of priests or holy men and women. The people for whom their ritual activity is done, patients, have been present all along in this and the preceding chapters as well as, naturally, in the course of my fieldwork in south India. The ayurvedic patient is the primary beneficiary of the changes wrought by ARM and the philological acumen of traditionally trained physicians like those I met and observed in central Kerala. The (re)establishment of wellbeing in the ailing and diseased is the end goal that has always propelled healing in Ayurveda; it's what motivated the people who reformed via ARM; and it continues to inspire the people who practice it today. What does it mean to be a patient, to be a person in need of help to realize wellbeing in one's life? The answer to this question is integral to assess the nature of healing concerns in Ayurveda, and it might offer insights when posing the same question to other medicines. In a very real sense, medicines begin and end with patients. They embody illness and make disease "real" for physicians. Without them remedial theories cannot be applied, tested, and utilized to promote health and longevity. The patient is the indispensable explanatory target of the Sanskrit medical classics and, hence, of the practice of those texts. In the concluding chapter, I ask what the Sanskrit sources tell us about patienthood and probe the south Indian gurukula for ayurvedic articulations about patienthood, healing, and wellbeing.