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Texts in Practice and the Ayurvedic Patient

In the previous chapter's discussion of ritual in/and medicine we saw how consideration of a healing procedure in the south Indian ayurvedic gurukula, and of healing contexts generally, can be useful to challenge long-held assumptions about rituals and propose new ideas and applications for ritual theory. Blowing therapy (*ūtu,* Mal.) is on the surface a noteworthy healing procedure: it is effective, first and foremost, and its materia medica and their application are potentially beneficial to comparative medical research. But there's more to the study of *ūtu* in the previous chapter than its effectiveness. To parse the ways that Biju practices texts to save snakebite and other poisoning victims can also be a helpful analytic case study for the critical reevaluation of concepts we use to explain interpersonal activity. A combined ethnographic and philological study of *ūtu* is instructive and illuminating because the performance of this therapy, its actors, and aims spur us to rethink previous assertions in scholarship about ritual and religion, as well as the links between these analytic categories. If we press further and think along with Bhaskaran, Priyankara, and Biju as they do things with textual knowledge to heal, it appears that the effectiveness of gurukula philology and textual practice rests on an ayurvedic physician's ability to sway, from illness to wellness, the necessary yet often ambiguous figures the literature of classical *āyurveda* has as its focus: patients. In this final chapter, I reflect on the practice of texts as a formative process through which vaidya-gurus draw on established models of wellbeing and attempt to manufacture aspects of those designs for students and the patients who consult them as they try to make sense of the experience of illness.

Healing is real, and wellbeing is manifest not in abstractions or literary musings on the body. The healing knowledge of *āyurveda* that was compiled in the first half of the first millennium CE and established in the big trio is intended precisely for people who *need* it, recalling the discussion of *vidyādāna*, the gift of knowledge,

in chapter 3. These people lack wellbeing, or their health is compromised in some way. We know that the tradition calls these people rogins, and that they are "patients" in a general, cross-culturally familiar idiom. They are "sick," "diseased," and "impaired" according to the basic meaning of the Sanskrit adjective *rogin*. As I have done throughout this book, this adjective is frequently nominalized, so that a rogin is someone who is sick/diseased/impaired, or a sick/diseased/impaired person. The healing knowledge of *āyurveda* proposes ways to inspect and treat many of these people. Like patients of any medical tradition, ayurvedic rogins go to healing experts to share their experiences of illness with the hope of getting assistance to overcome, mitigate, or manage their afflictions. Healing experts in south India's gurukulas, like Biju, his mother and grandfather, have been implementing knowledge contained in premodern Sanskrit and Manipravalam texts for generations of rogins. Biju continues to do this today, practicing these texts at Mookkamangalam with his students and the occasional assistance from Priyankara. His mastery of these sources, his reading and teaching of them, always points toward some kind of tangible healthcare. The ideas of healing and wellbeing adumbrated in the texts Biju practices cannot lead to treatment in the absence of patients, for whom these concepts reveal themselves as real-world states of being.

READING FOR HEALING

If the practice of texts in the ayurvedic gurukula has some things in common with textual-hermeneutic traditions of philology and medical practice in Europe and the United States, it differs in the ways that a rigorous study of classical texts is designed to set up immediate, sometimes urgent, applications of the meanings in those texts to contemporary problems. Put another way, gurukula philology entwines the study of classical healing knowledge with the treatment of contemporary medical problems. Neither side of this two-part practice is particularly unusual. Philology endures and even thrives in certain corners of academia, and procedures in biomedicine and other medicines continually advance through research and testing. Progress in biomedicine does not rest on philology, however, and the extent of the influence of the discipline of philology on medical research in either overt or direct ways is negligible. Practically speaking, the philological study of classical Greek, Latin, and Arabic thinkers recognized as the ancient and medieval composers (and compilers) of biomedicine's foundational literatures, academicians like Hippocrates, Galen, Paul of Aegina, physicians at the Academy of Gondeshapur, Ibn Zakariyya al-Razi, Ibn Sina, Rogerius, Vesalius, and others, is generally the remit of the history of science and medicine, not medical schools that train physicians.

In the United States in the twenty-first century, whenever historical aspects of biomedicine enter medical school curricula, they tend to appear as electives and

seminars set apart from the actual work involved in the administration of medicine. Many medical schools nowadays make history of medicine, technology, and science units available to med students on their university campuses, and doctors-in-training who are interested can learn about developments in biology and anatomy, social approaches to epidemics, and ethical debates in medical experimentation as well as, fairly recently, literary depictions of healing and science in medical humanities programs. At the time of writing, as the Covid-19 pandemic and the various bio-psycho-social ailments it has instantiated among people the world over moved past the twenty-month mark, scholars in the United States have been urging medical schools to recognize the value of the humanities to both givers and receivers of healthcare and to implement (more) humanities classes in post-Covid medical school instruction. "Medicine is not a science but an art," Molly Worthen writes, "that uses science as one of its many tools." The humanities, she continues, "do more than shed light on the cultural context of disease. They can also help doctors connect with patients as multidimensional beings."[1] There are also some medical schools in the United States where medical students do learn the discipline of philology in cursory ways that pertain to their work. Such programs tend to be housed in classics departments offering courses on Greek and Latin medical terminology aimed at familiarizing med students with Greek- and Latin-derived anatomical nomenclature.[2] Though noteworthy, these programs are rather different from the gurukula philology at Mookkamangalam and Shantimana and the lessons on Vāgbhaṭa's *Aṣṭāṅgahṛdaya* I have written about in this book. There are, perhaps, more similarities with the level and intensity of Sanskrit requirements on the BAMS syllabus in India's ayurvedic colleges today.

For the most part, the operative literary bases for contemporary biomedical practice in university departments of biology, dermatology, toxicology, immunotherapy, etc. tend to be quite recent productions, circa the early-modern era. Biological sciences like botany, zoology, paleontology, and embryology were professionalized in the eighteenth and nineteenth centuries, alongside major developments in cell theory, which Darwin synthesized in his theories of evolution and natural selection. At the same time, physics and the natural sciences were exploring and understanding in new ways how the operation and flourishing of the human organism is tied to geography and environment. Germ theory matured at the end of the nineteenth century, and genetics rapidly developed only in the first decades of the twentieth century. Curricula at biomedical schools today need not, therefore, and many do not, include medieval and ancient historical developments that set up scientific progress in the modern era, prompting the "ologies" familiar to us today that are associated with particular areas of healing and specialization.

Apart from all-purpose considerations of medical etiquette handed down from Hippocrates, "the father" of modern biomedicine, much of the history taught in biomedical schools focuses on early-modern science and medicine, the effects of which are still noticeable today, and it routinely ignores the influence of Persia and

Islam. James Shedlock, Ronald Sims, and Ramune Kubilius studied the curricular placement of medical history at medical schools in the United States, giving special attention to the Feinberg School of Medicine at Northwestern University, their home institution. They discovered that history courses and the literatures of the medieval and ancient worlds that historians consider the bases of western medicine did not require students to spend time with actual writings like the *Hippocratic Corpus*; Galen's *Method of Healing*; Paul of Aegina's *Medical Compendium in Seven Books*; Ibn Sina's *Canon of Medicine*; al-Razi's *Fatal Diseases*; Rogerius's *Practice of Surgery*; and Vesalius's *On the Fabric of the Human Body*. Instead, they found that if students training to become biomedical doctors in the United States today get to know these works at all, they encounter them as history, display objects in museum galleries, or librarians reveal them as special editions on tours through rare book collections. They are not sources for obvious integration in med students' clinical work.

The Feinberg Medical School's curricular expectations for the history of biomedicine and biomedical literature is representative of medical schools across the United States, Shedlock and his colleagues argue, and their research intimates the same is true for places elsewhere around the world where biomedicine is the modern establishment medicine, as it is in India. Following a comprehensive two-year study of student evaluations written by Feinberg med students who took history and/or medical humanities courses, the three researchers deduced that

> most students did not find the history of medicine seminar useful in a practical way. Student comments indicated that learning the history of medicine is important for what it teaches them about the medical profession and how it has developed over time via the science and art of medicine. As with other humanities seminars, this seminar *is not designed to be practical for learning or practicing current medicine*, but to help students understand the ethical, cultural, and social context of medicine.[3]

This finding is striking. The bracketing of *the practice of medicine* as somehow isolable from society, ethics, and culture is not unusual in biomedical discourse, and it has been increasingly common in BAMS-granting colleges in India. Recall, for example, the studies of Shailaja Chandra and Bode and Shankar, whose interviews with ayurvedic college graduates revealed considerable dissatisfaction with the BAMS degree for the ayurvedic college's failure to discuss Ayurveda's history and classical literature as pertinent to modern practice.[4] The development of the ayurvedic college system during ARM facilitated essentially the same situation that exists in the usual course of studies at biomedical schools in the United States. For aspiring physicians, there is a disconnect between the study of foundational medical texts and contemporary healing practices.

The practice of texts at Mookkamangalam hangs on the idea that reading should be workable. Bhaskaran taught his daughter and grandson how to make sense of texts for the purpose of healing sick people, people with physical (and

occasionally mental) problems who consult them because they need assistance, sometimes urgently. Modes of philology in Europe and the United States have been and still are mainly academic pursuits, in the sense that an "academic" enterprise involves processes of reading and thinking as opposed to practical and technical work. Which is to say that philology in Europe and the United States has been a form of critical scholarship, including how it has conventionally been applied to Indian sources (Classical Indology). It is largely divorced from the type of applied research that many scholars do in the social sciences and policy studies, research that impacts political decisions, actuarial calculations, advertising, and other areas of daily human life both familiar and tangible to many people. I neither mean to diminish the value of philological research in the humanities nor to say that our understanding of societies is not heightened by philological studies of classical texts. It certainly can be, and the conscientiousness and social awareness this research sometimes sparks can spur progress in the present day on issues of social justice, political and military reform, educational development, and more. But for all the good this kind of scholarship might do to edify and enlighten people about their social, political, and religious lives in the twenty-first century, maybe even motivating them to rethink their community and civic involvements, the reality is that work done by classical Indologists and scholars of arcane Latin and Greek texts simply is not readily available to everyone, at least not in the United States. It is not popular media.

That said, in South Asian studies, religious studies, and history many scholars have tried to make sense of old texts to level cultural critiques in the current moment and, in some measure, call for and possibly contribute to social, political, economic, and religious change. The kind of philological scholarship I have in mind here, even the most trenchant and award-winning, is commonly slow to influence the public sphere, however, if it leaves the halls of academia at all. Sometimes it does not leave, and merely circulates throughout scholarly subfields. But other times, when the connections between text and society are understandable, compelling, and apparent, the work finds its way to syllabi and students, and in this way textual research stands a chance to have social and cultural impact. Sheldon Pollock's work on the *Rāmāyaṇa* in this regard was seminal in the study of India and South Asia.[5] He showed us clearly how this deeply seated Indian cultural text inspired the ascendancy of the BJP in the 1980s and illustrated why and how the BJP used the Rāma story (*rāmakathā*) and rhetoric of the Ramjanmabhoomi Movement to mobilize Hindus under the banner of Hindu Nationalism, igniting communalism and inter-religious violence not seen since Partition. In Pollock's philological practice, we see that the ambitions of some Hindus to treat myth as history influenced how a powerful political group derived meaning from the *Rāmāyaṇa* and, in this particular case, how this worldview served the nefarious ends of state-sponsored intolerance and violence. In religious studies, a little over a decade after Pollock's work on India's epic literature, Bruce Lincoln published *Religion, Empire, and Torture: The Case of Achaemenian Persia, with a Postscript*

on Abu Ghraib, displaying how philological research as political critique could be done not only across vast expanses of time, but also across cultures of imperialism. Lincoln's reading of Achaemenian royal inscriptions (circa 553–330 BCE) illuminates the American military's sanction of torture in the wake of George W. Bush administration's response to 9/11.[6]

Naturally, it is difficult to gauge whether or not Pollock's or Lincoln's takes on the political affairs of the 1990s and early 2000s were noticed by people in power in India and the United States, or if their clarion calls to place checks on political leaders and their rhetoric in times of national emergencies influenced critical masses of citizens to demand change. At the very least, studies like these and, in countless comparable history books that overtly show or subtly suggest parallels between the Roman Empire and modern empires like the United States, model the methodological reach and incisiveness of philology, bringing the critical reader's positionality to bear on hermeneutical work.[7] By describing exploitations of political power and the overt use of religion to legitimate hostilities against Muslims in India and the use of torture both to quell dissent in ancient Persia and to extort confessions in modern-day Iraq, Pollock and Lincoln move through the initial two registers of philological meaning-making discussed in the introduction, text and context, to show that scholars' politics and relations to the texts they choose to study impact meaning-making in philology. Nevertheless, the stakes of the effort to "heal," broadly conceived, to expose injustice and oppression in these two philologies of the past in the service of the present, were aimed at broader, more socially incremental and progressive change than gurukula philology, where the stimulus to reify wellbeing for the sick is far more immediate.

As we have seen, applications of healing knowledge contained in Sanskrit texts do not simply transpire as vocal recitals, as one might expect in a mantra-based medicine or the glossolalia-inflected healing that happens in Pentecostal churches. Historically, the gurukula-trained student memorizes large portions of texts, sometimes in their entireties, to facilitate intertextual associations, across multiple languages in some cases, so that texts and ensuing reconfigurations of collections of texts may be used as instruments of healing. The healing part of this method is part and parcel to gurukula philology, to the practice of texts. It is not merely a beneficial aftereffect. Healing is the material occasion of the ideas (theory) about what constitutes wellbeing established by the compilers of the classics of Caraka, Suśruta, and Vāgbhaṭa and those who came after them, experts who worked out the expression of wellbeing by composing commentaries and spinoff texts. An example of wellbeing "made real" signals a moment in the practice of texts for the creation of new texts that will be taught, both for students and the people upon whom healing concerns begin and end: patients.

To appreciate the unyielding effort put forth to practice texts at Mookkamangalam and Shantimana, it is not enough to recognize that the *Aṣṭāṅgahṛdaya* or the big trio informs the healing work of the vaidya-gurus at these locations. The ways that Biju, Priyankara, and Bhaskaran have and continue to implement texts

in their clinical work is an ever-changing and impromptu formative process that conceives, assesses, realizes, and manages wellbeing on a patient-by-patient basis. Each clinical procedure is thus transient, entailing reconstructed remedial information, and it requires a specifically curated rendering of wellbeing to suit new and different clientele and contexts. By choosing to transmit the ayurvedic tradition and treat patients on the basis of principles in the classical Sanskrit collections and associated regional sources, Priyankara and Biju today; Bhaskaran before them; and the students appearing in this book all actively mediate and organize an unfixed stream of medical realities that include notions of health and wellness and modalities to achieve these ideals.

In the course of much of the research and fieldwork for this book, I did not understand or "use" texts as the vaidya-gurus at Shantimana and Mookkamangalam did. Aware of this difference, and in an effort to articulate it, I would speak with Biju and Priyankara about their perception of texts whenever I visited them. In my earliest visits to Mookkamangalam, I typically showed up each day with a stack of Sanskrit and Malayalam sources that I hoped to read with them, or with any of their students who might have been interested. I wanted to understand what the texts said and how their compilers approached the matter of healing. But I was reaching for a wide-ranging knowledge of ayurvedic history, its technical language use, and what ayurvedic healing looked like *back then*, whenever the sources I happened to be working on were produced. I was attempting to locate a south Indian literary culture of healing, in effect, by identifying seminal texts that could be placed in a tidy chronology and taxonomy across medicinal fields, such as snakebite treatment, other poison treatments, astrological healing, and embryology.

Biju was always more comfortable about my preoccupation with "ordering" Indian medical knowledge (and knowledge production) than Priyankara was. My interests were not new to him. He had been enrolled as a student at an ayurvedic college briefly, though he never got his degree, and in the late 1990s and early 2000s many of his mother's students were about the same age as him. He tended to connect with them socially, as members of the same generation with similar cultural references, and he developed friendships with many of them. He was also very familiar with the style and content of the education that BAMS students had when they came to to study with Priyankara. The Sanskrit texts on the ayurvedic college syllabus were treated like history books, he used to tell me. Holding up a copy of a Devanagari edition of the *Aṣṭāṅgahṛdaya* slightly above his head, in 2015 he observed, "books like this tell BAMS students important ideas in Ayurveda. Naturally they do this. But most students never read all of them or appreciate them as tools [of healing]." When he said this we were sitting on the veranda along with three of his students, two men and one woman, who were studying with him during a short break from their respective colleges in Karnataka, Kerala, and Tamil Nadu. We had just finished six hours of mukhāmukhaṃ lessons and five patient

visits spread across the day. Everyone was tired, a little slap-happy, and everyone was just about ready to call it a day. I casually floated one last question to the group. "How do you think about the movement of ideas from texts like Vāgbhaṭa's collection to patient care and how is this movement explained at the college and at Mookkamangalam?" The twenty-one-year-old woman who studied in Tamil Nadu, Thankam, responded with unexpected energy. She didn't quite answer the question I had asked, but instead described a history of the modern college syllabus that she and all BAMS students had to follow. To her it seemed that long-gone administrators had re-positioned the Sanskrit she studied with Biju as a symbolic marker of a tradition from a time before classical Indian healing got mixed up with non-Indian medicines.

By this time, I'd been visiting central Kerala for over a decade, and I had heard variations of this history many times. Thankam's parents were ayurvedic physicians. Her grandfather had been one as well, and she had studied in an ayurvedic gurukula in Tamil Nadu at a site she imagined was set up like Shantimana, which she had learned about from Biju and Priyankara. Her desire to connect with the history of the healing tradition she was about to enter as a professional became noticeably political, eliminating any residual lighthearted silliness among us on the veranda. "Ayurveda is self-sufficient," she said. "It is effective, too. It is frustrating to spend so much time studying for a career in Ayurveda at college that looks like a modern medical school. I have friends at those schools [studying biomedicine], and we do many of the same things. In fact, some seniors who graduated from my school now work at ayurvedic clinics and actually dispense modern [biomedical] drugs. What is Ayurveda now? These people never wanted to study Ayurveda anyway. The [ayurvedic] college is making it possible to practice modern medicine even when you can't get a seat in one of those schools. The college teaches modern medicine," she concluded, which I understood to mean that it is not *āyurveda* and therefore, somehow, possibly less Indian.[8]

I arrived at the model of gurukula education as *the practice of texts* over the course of meeting many students at Shantimana and Mookkamangalam who bemoaned what they viewed as the near erasure of the Sanskrit classics from training in the ayurvedic college. What do the Sanskrit medical classics provide an ayurvedic physician that the standardized syllabus of the colleges does not or cannot offer? Both institutions convey knowledge about the human body, health, and disease and demand that their students master it. A major difference that I observed among students at central Kerala gurukulas is that they learned how to improvise ayurvedic theory in ways that they did not feel they were taught or encouraged to do at college. BAMS students and graduates who also seek gurukula training at places like Mookkamangalam are looking for exposure to an epistemological framework that facilitates the nimble application of healing theory that is, in their minds, ayurvedic rather than the hybrid bio-ayurvedic model taught at colleges.

For a BAMS student training with Biju, what sets the texts studied in the gurukula apart from modern medical texts studied at the college? The language of composition is one obvious aspect. For many of Biju's students, the fact that they do not learn about Ayurveda's materia medica, methods of diagnosis, and healing procedures *in Sanskrit*, apart from an introductory course in the first year, is disconcerting. For them translation signals a watering down of *āyurveda* and a reworking of the Indian tradition towards western models of diagnosis and treatment. This isn't the entire story, however, though it certainly drives some students' perceptions of what is real or pure Ayurveda (*śuddha*) and what became known as the mixed tradition of Ayurveda (*miśra*) during ARM. The mukhāmukhaṃ format teaches a workable approach to reading and that has the single biggest impact on gurukula students, especially on those who were able to spend more than a few months studying with Biju, Priyankara, and Bhaskaran. The practice of texts instils a practicable epistemology.

"How do you think about the *Aṣṭāṅgahṛdaya* versus other types of literature?" I probed Biju in 2017 during the last stretch of fieldwork I did for this book. "I understand that the content is often different. But you have also told me that Vāgbhaṭa's collection is different than other medical sources, that it teaches an orientation for thinking and perception as much as it teaches data and ideas about the body." "That is all there," he replied. "It has to be. But it is not primary. Anyone can learn these things. Many people do. But when I used to sit mukhāmukhaṃ with *muttacchan* [grandfather]," Biju expanded,

> he did not want me to read Vāgbhaṭa like I read O.V. Vijayan and M.T. [Vasudevan Nair—two famous Malayalam authors]. He taught me to memorize the *Aṣṭāṅgahṛdaya*. When he taught me to recite it, he taught me how to think about the words, carefully, in relation to each other. We call this *saṃhitā* medical because treatments, drugs, disease, *doṣa*s, and more are in there. But I had to see these things as devices to improve the sick person. Vāgbhaṭa gives an approach. So, when I memorize it, I can recall any part and apply it to correct a patient's problem. This is not how I read novels. Yes, ideas and images in good novels stay with me long after I've read them. But I did not read them in the first place to use later with others; not to comfort or relieve others. I did not read those books because they are technical or I thought they could be useful one day.[9]

Biju's reflections on what distinguishes ayurvedic from popular literature drew to mind something Priyankara explained to me in 2004. I had asked her why recent BAMS graduates wanted to study with her after they had already been licensed by the government to practice Ayurveda, and she told me: "because I teach them how to think."[10] There are concepts and there are procedures to be learned and remembered in an ayurvedic gurukula education, just as students are tested about the pharmaceutical properties of plants and human anatomy on exams at ayurvedic colleges. But Biju and Priyankara imagine the medical classics more like

a perspectival orientation for assessing and, when possible, pacifying and bringing order to changing and unstable patient scenarios. They do not consider their primary objective to be the transmission of data to rehash on exams for grades, of which only a handful turns out to be useful in a student's post-BAMS specialization. They teach the *Aṣṭāṅgahṛdaya* to promote and cultivate the ability to adapt and improvise across multiple branches of medicine no matter what the circumstances are or what patients bring to them (though they do not perform all types of medicine at Mookkamangalam, avoiding such procedures as bone setting and any kind of surgery).

"The ability to think about Vāgbhaṭa's words, in several ways, is important to my practice as a physician," Unnikrishnan told me in 2013 as we drove to northern Kerala, away from Mookkamangalam, after my visit with Biju was cut short by the unexpected death of his father. I stayed on at his *mana* for a while to offer my condolences and help Biju and Priyankara however I could. Ultimately my presence seemed more distracting than helpful, as their family obligations and assorted funerary rites grew more time-consuming. So, after Unnikrishnan paid his respects to his two gurus, he collected me and my things and took me on a tour across Kerala's winding backroads and interstates north of the Thrissur District. We went to his hometown, visited his small pharmaceutical manufacturing plant and the ayurvedic hospital where he worked, and toured the college where he was a newly hired professor.[11] His career was taking off, and he was eager to extend his deep understanding and appreciation of Ayurveda into diverse related projects. But despite the many things that I learned about Unnikrishnan's life since receiving his BAMS degree and training at Mookkamangalam, most of our conversation on that drive was not about Ayurveda, but about our mutual friend and his family.[12]

Unnikrishnan and I made almost this very same trip again in 2017. On the latter drive, knowing I was close to wrapping up my fieldwork for this book, I pointedly asked him to tell me about his early days studying with Priyankara, back when I first met him in 2004. I spent a lot of time at Mookkamangalam in 2004 and 2005, and on most days he picked me up in the mornings at my hostel, and took me on the back of his motorcycle to observe his lessons with Priyankara and Biju and their interactions with patients. Later in the evenings he took me home, usually after nightfall when patients were not likely to show up for consultations. From the first motorcycle ride, it was easy to talk with Unnikrishnan. He is kind and easy-going, with a nonchalant wit and intelligence that's magnetic. When I observed him during mukhāmukhaṃ lessons, it was obvious he was an excellent student. So, it is no surprise to me that he is a beloved professor and physician today. In 2004 and 2005, this tall, sturdily built Malayali man in his mid-twenties, clad in a t-shirt and a white mundu day after day, had Priyankara and Biju's constant trust, speaking on their behalf to patients and routinely issuing

their prescriptions. "What do you remember most about studying at Mookkamangalam and working with Priyankara and Biju?," I asked him in 2017 as we drove past the hustle and bustle of several Kerala towns.

> I didn't cram there, studying for a test the next day like I did at college. Priyankara tested what I knew by asking me to recite portions of the *Aṣṭāṅgahṛdaya* or to refer to a work in Malayalam that could address a patient's needs. This was eye-opening. Vāgbhaṭa's *saṃhitā* is more than a textbook with facts about the body, herbs, and theories. It's broader than that, but of course still useful for specific problems. It's about how to see and look at problems. It helped me think about the questions I should ask patients about their bodies, and ultimately how to treat them.
>
> [I asked what he meant by saying that Vāgbhaṭa's text is "broader" than a textbook.]
>
> Priyankara used the *Aṣṭāṅgahṛdaya* to show that illness is a basic human experience. Universal, in fact. The body suffers for many reasons. But under the influence of drugs, that experience can change and improve. Priyankara and Biju understand *doṣa, rasa*, and *dravya* as well as anyone I know, and they taught me using technical language, language I use in the classroom now. Some of the terms they taught, I also heard at college; but some [of those terms] were put into allopathic terminology at college, and I learned their original meanings with Priyankara. But it's what they do with these concepts when they meet patients that deepened my understanding of *āyurveda*. They can speak the knowledge of Vāgbhaṭa and give it to patients so they can understand their experience of illness and how to change it. This kind of conversation is hard to have today because the Sanskrit texts are complicated. Hardly any patients know them. But they [Priyankara and Biju] still find ways to do this every day, with people from all walks of life, in ways that appear direct and simple. They chat about a patient's life and what it means to have and care for a body. That's life, isn't it? Everybody can relate to that.[13]

I asked nearly every student I met at Mookkamangalam why they went there to study. I knew what had initially brought Unnikrishnan there. But I wanted to hear him explain it again, while we were insulated from the distractions outside of his air-conditioned car. I thought maybe he would elaborate on his earlier answers to this question, which usually amounted to something about his seniors at the ayurvedic college he attended in Karnataka encouraging him to meet Bhaskaran and one of his professors there who also spoke about this remarkable vaidya-guru and his family of healers. In the break before his last year of college, Unnikrishnan drove his motorcycle from his college town in Karnataka to Mookkamangalam and asked Priyankara and Biju if they would let him take an apprenticeship. I had never fully understood the details of Mookkamangalam's appeal for him personally, however, and I wanted to know if there was something more that motivated him than an answer that seemed to boil down to "everyone else was doing it."

"Remind me what brought you to Mookkamangalam in the first place," I nudged him. He told me that at the time he still had another year to complete his BAMS and that he was doing well at college, receiving high marks. When he

graduated, an excellent opportunity awaited him to move into private practice in his hometown in northern Kerala. He knew he liked Ayurveda not only to practice but as something to study, a perspective he had developed by working with a foreign scholar who employed him to work on some translation projects. This scholar's ardent interest in creating an archive of traditional Ayurveda in Kerala and in translating some of the writings of well-known Malayali vaidyas in the twilights of their lives also spurred Unnikrishnan's interest to meet Bhaskaran and study with Priyankara, over and above the precedents set by his college classmates. Years later, his academic curiosities led him to a dual career as a physician at a private hospital in his hometown and as a professor at a prestigious ayurvedic college.

The work Unnikrishnan did at Mookkamangalam, he told me on our road trip, exposed him to an approach to diagnosis and treatment that he did not share with many, if any, of his colleagues at the college where he worked. I asked if his colleagues knew about his gurukula training, and he told me that some did, though they rarely talked about it. He suspected this part of his ayurvedic education might have created some jealousy among his colleagues. He speculated that those who knew he had spent years studying with Priyankara and Biju privately envied the opportunity he had to engage their shared profession in a traditional and regionally unique manner (mukhāmukhaṃ), though he hastened to tell me that no one openly admitted to feeling this way. Personally, he felt he approached his job as a physician and professor differently than his colleagues who had been trained exclusively in the college system. Priyankara taught him to see the context in which patienthood formed, developed, and could be managed through a broader lens than his college training did. In the ayurvedic college classroom, first as a student and now as a professor, he felt a narrowing of the medicine that seemed open and impromptu at Mookkamangalam. Knowledge about sickness, the body, and healthcare that he shared and discussed with his students was absolutely vital, fundamental to the effectiveness of Ayurveda, and he was proud to teach it. His delight was also obvious when he talked about the academic progress and professional achievements of his students.

But Unnikrishnan understood that today's ayurvedic college education is scripted and tailored to the exam structure of the CCIM syllabus, and he reckoned this equipped his students with an understanding that equates the patient with the disease she presents, and to treat disease as a thing-in-itself. The patient's intensely personal experience of disease, what Lisa Diedrich calls "the patient's vernacular," is glossed over in this setting.[14] Instead, a less inclusive and undemocratic narrative predominates. It homogenizes patients in predictable categories and sees disease as a somatic verity isolable from the body and the person who bears it, shorn of cultural conditions that generate sickness and impact suffering, such as sex, gender, class, caste, and race. "The patient is individualized, and yet still objectified," Diedrich explains. "That is, she is individualized as a body, not as the subject of her own experience."[15]

The interaction of vaidyas and rogins at Mookkamangalam makes room for the inclusion of the patient's experience and her articulation of it in the evaluation of illness (*rogīparikṣa*) that determines treatment. This demands a level of spontaneity and willingness to create extempore illness narratives anew with each patient that, for Unnikrishnan and his gurukula teachers, are naturally informed by a deep understanding of Vāgbhaṭa's classic. The *Aṣṭāṅgahṛdaya* serves as epistemological scaffolding for an assessment that must be shaped in the end by the information patients and their attendants disclose. A thoroughgoing understanding of disease alone is not sufficient, as Unnikrishnan explained to me.

> We read large portions of texts together, not just one or two *śloka*s from *Caraka* or the *Aṣṭāṅgasaṃgraha* or *Aṣṭāṅgahṛdaya* that you might stumble through as a class in college. Priyankara showed me how to read a text like the *Aṣṭāṅgahṛdaya* in conversation with other texts and in relation to past practices with patients. She taught me by reading with me, and quizzing me about what we read, but most importantly by letting me help daily with patients. I am now a teacher of Ayurveda, teaching a specialized subject, and I cannot express the same kind of information to my students like she did for me. I tell them what they need to know. But showing them how to think with this knowledge, how to respond with this knowledge as a guide for each new patient and each new story that accompanies a disease or problem you can perhaps identify straightaway. . . . That can difficult in a lecture hall. The gurukula was more like an apprenticeship. It is not quite the same in the college or the hospital.[16]

WELLBEING IN THOUGHT AND PRACTICE

If the hallmark of the south Indian ayurvedic gurukula is its classical texts-to-treatment continuum, then mukhāmukhaṃ training communicates this field of healing and shapes its practice. The college curriculum repurposed the connection between instruction and healing—updating or "making it modern," as Rachel Berger put it—by reinterpreting classical *āyurveda* and the classical corpus through the scope of biomedical categories and fields of inquiry. This has the effect of creating a new framework for teaching and practicing Ayurveda, far removed from the type of medicine Bhaskaran studied in his youth. This reminds us that the *āyurveda* of the Sanskrit classics has endured through the centuries, though in multiple interpretations and iterations. Changes during ARM mark a recent adaptation of the classical tradition to new and changing times, demands, and future prospects, and there will be others as long as Ayurveda perdures.

We can therefore speak about many and various Ayurvedas, past and present, as well as future Ayurvedas. With each milieu the framing and application of classical *āyurveda* displays unique conceptions and restatements of the tradition's central tenets and objectives. A decade ago, Gregory Fields reasoned that efficacy in healing traditions throughout history and around the globe has been judged by their ability to articulate two conceptual rubrics: on the one hand, there is a positive rubric of wellbeing that includes themes such as freedom from disease

and helplessness, adequate vitality to accomplish life goals, and feelings of welfare and comfort. On the other hand, there is a practical rubric of healthcare that delineates treatment and preventative modalities for bodies as well as socio-economic issues that implicate things like access to medical care, health education, and the means to pay for medical care.[17] Both rubrics are apparent in the earliest Sanskrit literature that subtends contemporary Ayurveda and the rehearsal of that literature at ayurvedic gurukulas, clinics, and hospitals today. Yet, wellbeing in classical *āyurveda* is an expansive and variously imagined concept. It is aligned with but also more than "freedom from disease," the literal meaning of a key ayurvedic term, *ārogya* (a *taddhita* or "nominal affix" derivative of *aroga,* "free from disease"), which connotes the experience of health most people enjoy at times in their lives, although never perfectly nor, naturally, forever. Of course physical and mental disease and impairment do not obviate the chance to experience health. But the experience of health, individual as it is, is but one piece of an unrealizable ontological state, so-called wellbeing. Such an ideal sets the parameters for pragmatic inquiry and action in pursuit of that ideal, H. Tristram Engelhardt, Jr. observes of medicines in general, by delimiting modes of diagnosis, prognosis, and therapeutics.[18] In these considerations, wellbeing appears to be a category for physicians to envision, a target that is aspirational rather than achievable. If perfect wellbeing is not possible, at least the conception of it, Gregory Fields supposes, "calls us to question what health could be like ideally."[19] Ayurveda offers practical methods and resources for people to care for their bodies and minds in pursuit of wellbeing, so that it might be more than an academic, professional aim.

Ayurveda's therapeutic methods and curative resources are for people who need them, as we saw in chapter 3, people the literature calls rogins: the ailing, infirm, diseased people whom we know as patients. The way that a long-established medicine like Ayurveda promotes a culture of treatment among its practitioners to care for patients is an important measure of the medicine's basic understanding of the human body and the nature of disease, and in many cases also its worldview about the human condition and its commitments to the cultivation of ethical standards like compassion. The reality of the patient—*that there is a patient at all*—grounds Ayurveda's medical theory and practice, as it does for most medicines. If wellbeing is a medicine's goal, then its practitioners must contend in some way with the nature of patienthood: the human experience of the evanescence of health over a lifetime and the ongoing awareness of the impossibility of endless health. Indeed, medicine reminds us that every one of us is a patient, at any moment and perhaps at all times. This is an ontological outlook of many established medicines, where pathology defines patienthood, and the existence of diseases as seemingly identifiable entities in bodies lends itself to the view that treating symptoms of disease in different bodies can be treated with similar remedies. This outlook tends to see patients broadly as a collective according to their classes of disease and somatic dysfunction. But patienthood is individual. The experience of changing health over time is personal and inimitable. Depictions of rogins in the Sanskrit classics do not include

the patient's vernacular, however. That voice lies outside the ambit of the texts. They are essentially professional workbooks, having been compiled and redacted over centuries so that physicians can attend to manifest symptoms of illness, misfiring organs, and broken bodies. With this understanding, we can read the Sanskrit medical classics as Michel de Certeau perceived "modern medicine." With few exceptions, these classics see, make legible, and make sense of bodies, not persons or lives lived with unfolding matrixes of consequences stemming from the engagements of social actors.[20] De Certeau's remarks on medicine in seventeenth and eighteenth century Europe apply also to the earliest literary cultures of Ayurveda in South Asia. "Thanks to the unfolding of the body before the doctor's eyes, what is seen and what is known of it can be superimposed or exchanged (be translated from one to the other)," he wrote. "The body is a cipher that awaits deciphering." When patients' bodies in ayurvedic literature are "exposed to erudite curiosity through a corpus of texts," as de Certeau observed of European medicine, the singularity and heterogeneity of patienthood fades in the process, and is reconstituted as a given

> in the rift between a subject that is supposedly literate, and an object that is supposedly written in an unknown language. The latter always remains to be decoded. These two 'heterologies' (discourses on the other) are built upon a division between the body of knowledge that utters a discourse and the mute body that nourishes it.[21]

Patienthood is completely unexceptional. Because the objectified status of being a patient is so fundamental to human nature, the ayurvedic rogin is a generic marker that, apart from the identifiable diseases and malfunctions that parse out different groupings, expresses something we all share as humans: ongoing physical degeneration and the need for medical intervention at various times in our lives. We are all always patients.

If wellbeing for sick people is sought as a goal in Ayurveda, even if it's ultimately unachievable, the tradition's name brandishes the banner of long life, *āyus*, which would seem to be an unimaginable state without wellbeing. Or, put another way, *āyus* minus wellbeing would be a most unfortunate state of being. Yet, the idea of wellbeing is far from straightforward or uniform across classical ayurvedic literature. It is just as plastic of a concept in Sanskrit as it is in English. It can mean multiple things and, possibly, mean something different for every person. In English wellbeing can refer to a single person or a community. It can speak to states of health, happiness, and prosperity. It can be qualified by physical, psychological, emotional, and moral senses of welfare. It is in the latter two instances especially that interpretive space opens up for the reading and description of Ayurveda as a spiritual or religious medicine that attends to holistic concerns of the human condition, as it is has often been portrayed in the United States since at least the 1970–80s New Age Movement. With such an expanse of potential meanings, can we even begin to understand wellbeing amid the many Ayurvedas of the two millennia since Caraka's collection was codified?

A typical response to this kind of inquiry is to look at the texts, searching for ideas in the Sanskrit classics that might translate as wellbeing. Sanskrit is a synonym-rich language, and when it comes to a symbolic and philosophical concept like wellbeing, there are numerous ways to label it generally (or aspects of it) and to describe it by referencing contexts where it is likely to manifest. Lexicographers and scholars have often taken *svāsthya* and *susthiti*, both of which mean health, contentment, and a sound physical state, to signify wellbeing. Terms like *ārogya* and *nirāmaya* carry the more pointedly "medical" understanding that wellbeing implies freedom from disease and dysfunction. Similarly, *sātmya*, wholesomeness or somatic fitness, grounds the notion of wellbeing on the suitability of a person's relationships with others and the environment. Occasionally, the sprawling states of happiness and enjoyment captured by the term *saukhya* are also linked to (or at least implied in) the idea of wellbeing. The views of illness, healing, and wellbeing that emerge in Caraka's collection appear to reflect a theoretically grounded bailiwick more than a specialty per se, as we see in the works of Vāgbhaṭa and Suśruta, which are designed to inform remedial protocols and convey intricate anatomical mapping and manipulation. The *Carakasaṃhitā* describes the relationship between physical wellbeing and actions of people in the language of self-cultivation (*ātmahita*): "One wishing to make what's good for oneself should always observe good behavior in line with tradition."[22]

With a multifarious view of wellbeing in the literature, it is clear that none of these shades of meaning are realizable without an understanding of the context in which it is needed. We might therefore ask what constitutes a treatable person and how physicians tailor treatments to the specific people in whom they have identified disease. Even though we can adduce a litany of terms from the classics that say wellbeing is both this and that, it is achievable here and there, and so on, my observations of how Biju, Priyankara, and Bhaskaran handle the texts that support their healing practices suggest, first, that the usefulness of a text is contingent on the proficiency of the healers who use them and, second, that the notion of wellbeing ultimately rests in the somewhat inexact category of the patient. In the first case, chapters 2, 3, and 4 offered examples of Malayali vaidya-gurus demonstrating that they are skilled healers and rigorous teachers. The connection of wellbeing to the patient is where I turn now, as a way to draw to a close the larger discussion about how education and healing in the south Indian gurukula are yoked by the practice of texts.

PILLARS, TEXTS, AND HEALING

At Shantimana and Mookkamangalam, actors and their actions formulate and give real world shape to important ideas about "illness and other dimensions of medical reality," in the same way that Byron Good observed of doctors and students at biomedical teaching hospitals.[23] Gurukula philology is generative and

creative, which is to say it is health-giving and, even more, it is formative. Biju's clinical and teaching work re-present and extend in the present day interpretive exercises that were fixed in classical texts of this two-thousand-year-old tradition. The practice of texts at Mookkamangalam is an ongoing process, to return to Good's appraisal, involving "interpretive activities through which fundamental dimensions of reality are confronted, experienced, and elaborated. *Healing activities shape the objects of therapy*—whether some aspect of the medicalized body, hungry spirits, or bad fate—*and seek to transform those objects through therapeutic practices*."[24] When Biju, Priyankara, and Bhaskaran work through the Sanskrit medical classics' articulations about how to use knowledge (*veda*) to promote long life (*āyus*) with their students, the ideas of life and wellbeing—and their opposites, death and illness—are symbolic objects of knowledge. The compilers of the classical sources constructed them, and vaidya-gurus at a place like Mookkamangalam teach them, as objects of life science that "presuppose forms of imagination, perception, and activity."[25] Aspiring physicians acquire knowledge and learn technical healing language that is "ayurvedic," but in the abstract. Daily clinical work with patients, then, exposes gurukula students to unique ways of seeing and treating individuals. Gurukula philology moves ideas about wellbeing into the domain of material practice, where the mastery of texts previously studied dictates the likelihood of an effective diagnosis and treatment leading to wellbeing for the patient.

Scholars generally identify the origin of the knowledge Kerala's vaidya-gurus teach and practice in the oldest text of the great trio, the *Carakasaṃhitā*. Historical connections exist between the Sanskrit medical classics and earlier literature of the Vedic era, however, which spans a lengthy, if contested, stretch from roughly 1400 BCE to 400 BCE. For example, a text from the late-Vedic period, the *Ṛgvidhāna*, presents everyday ritual uses for the hymns of the *Ṛgveda*, and links the use of amulets and recitation of mantras with the eradication of disease and protection of good health.[26] Another late-Vedic text, the *Kauśikasūtra*, is more deeply medical than the *Ṛgvidhāna*. It contains a section on healing remedies (*bhaiṣajyāni*) that includes instructions for using talismans and charms, botanical herbs, and mantras in the *Atharvaveda* for remedial aims, such as eradicating jaundice, leprosy, diarrhea, headache, urinary retention, fever, and other diseases.[27] This text has another section on rites designed specifically for women that discusses how to ensure the birth of sons, normalize menstruation, safeguard childbirth, and protect the health of young children.[28] The *Kauśikasūtra* devised household uses for the mantras and materia medica of the *Atharvaveda*, which scholars since the nineteenth century have viewed as the oldest available source of healing literature in South Asia.[29] Some remedies in the *Atharvaveda* appear to have informed aspects of curative thinking in classical *āyurveda*. But on the whole, Atharvavedic observations about the causes and nature of wellbeing and specific methods for preventing disease did not endure in the classical tradition. Pragmatism, prognostic reasoning, and clinical know-how distinguish the *bṛhattrayī*, for example, and

the sympathetic-based solutions of the healing tracts in the Vedas mostly do not carry over in Caraka's collection and later texts we classify as ayurvedic.[30]

The enumeration of the four keystones of life science in the Sanskrit medical classics in effect institutionalized a new healing tradition in South Asia. Thus, the *Carakasaṃhitā* explains that *āyurveda* is based on a trio of people—physician, attendant, and patient—and remedies. Each part of this quartet (*catuṣṭaya*) is "endowed with qualities that should be known as means to alleviate disease," and collectively they are therefore indispensable to healing.[31]

Looking across the collections of Caraka, Suśruta, and Vāgbhaṭa, we learn a lot about this quartet, these four pillars (*pāda*s) as they are often called, which support and ensure the integrity of ideas and practices that have developed into the institution we call Ayurveda. We discover that the physician (*bhiṣaj*) uses knowledge of the structure and inner workings of the body to heal sick and diseased people. The attendant (*upasthātṛ*) is an assistant to physicians and helper of patients, making sure that prescriptions are understood and followed. The patient (rogin) is the embodiment of illness, often appearing as the material incarnation of disease and the physical site for the healing graft of therapies. Of the trio of people, the physician receives the most attention in the literature and the attendant receives the least. Medicinal substances (*dravyāṇi*) are treated at length, although, unlike the physician, who is critical to every healing intervention, the types of medicines in each collection are prioritized according to the specialty of the particular text. The patient is always somewhat elusive, appearing at times as little more than an inert body displaying ailments and symptoms, while at other times emerging as a socially active person whose behavior illustrates the links between health, comportment, society, and environment.[32]

The development of the healer as a professional expert versed in classical life science marks a critical separation of classical medicine in India from earlier healing practices in the Vedic era.[33] With the advent of classical *āyurveda*, the Sanskrit classics discuss and celebrate vaidyas for their education, sensibleness, and applied knowledge (*vidyā*). The *Carakasaṃhitā* states that people merit the title of vaidya when they possess certain qualities, such as "knowledge, reasoning, discernment, memory, diligence, and accomplishment," and they do "not turn away from anything that is curable." What is more, when a healer has

> knowledge, intellect, practical observation, discipline, success, and mindfulness—even just one of these is enough to merit using the title vaidya. But the person who possesses all these favorable qualities, beginning with knowledge, gives happiness to living beings and appropriately deserves the title of vaidya.[34]

The compilers of the *Carakasaṃhitā* explored the factors that someone might wrestle with in choosing to become a vaidya; they probed the decision to cultivate these qualities in oneself and propagate happiness in others. They asked what crafting a life for oneself defined by the general nature of a physician (*vaidyatva*)

might be like.[35] To appreciate such a decision, as we saw in the discussion of quacks and genuine healers in chapter 3, Caraka's collection invokes the drive people have to uphold *dharma*, the highest form of which is to shield from pain all patients like they are one's own sons.[36] After distinguishing the vaidya from the pseudo-physician (*vaidyamānin*), who merely pretends to heal, usually for monetary gain, the text's compilers characterize the *bhiṣaj*, a common title for healers in the Vedas, as inferior to the vaidya: "Those who get the title of *bhiṣaj* by observing a *vaidya's* instruments and medicines, books, and strengths are known as charlatans."[37]

Healing activities in ayurvedic literature that constitute the south Indian gurukula curriculum, as Byron Good notes of biomedical schools, shape the objects of treatment. The practice of texts thus brings ideas of wellbeing to bear on the people who present themselves for care. Among the qualities of the patient in the classics, ubiquity and flexibility are common. Although aspects of the patient frequently change from section to section in each collection—occurring sometimes as male, sometimes female; occasionally elderly, occasionally adolescent; at times sturdy and robust, at other times delicate and infirm—descriptions of the patient as a rogin mostly tend to be plain "pathological facts," to borrow Michel Foucault's phrase, with an anatomo-clinical gaze that sees disease primarily in the observable body, and extracts or parenthesizes the experience and voice of the patient from typical medical procedures.[38] Correspondingly, in an earlier study of patienthood in Indian medical literature, I showed how some of the most common terms used to designate the patient, such as *rogin, ātura*, and *vyādhita*, adjectives meaning "diseased," "sick" and "afflicted" used nominally to indicate a diseased, sick, and/or afflicted person, express social and ethical views about the incidence of disease as well as, possibly, in some instances, the experience of illness.[39] A typical way the compilers of the literature formulated the objects of their study was by transforming the generic rogin into the embodiment of a specific condition. A patient suffering from a host of urinary disorders known as *prameha*, which some lexicographers have translated as diabetes, is *pramehin*, and thus a diabetic; a patient troubled with *atisāra*, diarrhea or dysentery, is *atisārin*, a diarrheic or dysenteric; a patient with a *gulma*, abdominal tumor, is *gulmin*, a tumored person; and so on.[40] Patients embody and express diseases in this way. They are identified by their afflictions.

Of Ayurveda's four pillars, the patient is consequently the pillar most intimately linked to poor health and illness. Disease befalls the patient, and in the changing representations of a patient's body pathologies develop, subside, and resurface. The patient is arguably the one absolutely necessary part in the *Carakasaṃhitā's* articulation of the tradition's foundational four components, the thing without which ayurvedic knowledge could not formulate and identify diseases and ultimately apply therapies to treat them. Where would human diseases form, exist, develop, and be treated without them? Yet the classical compilers of the literature don't ask this question, in this self-reflexive way, about the crucial target of the tradition. That said, they do suggest some general agentive qualities that make

patients more than just personifications of disease. The *Carakasaṃhitā* offers a few additional notes about traits in patients that facilitate healing and treatment that shed a little light on this figure. The text states that physicians will have the most success treating patients who have good memories, are compliant, demonstrate fearlessness, and are informative.[41] Informative (*jñāpaka*) patients can express the nature and history of their ailments in detail, enabling the physician to make accurate diagnoses and administer suitable treatments. Compliant (*nirdeśakārin*) patients will observe the physician's diagnosis and adhere to prescribed medicines and healing protocols. The most authoritative and comprehensive commentator on the *Carakasaṃhitā*, Cakrapāṇidatta (eleventh century), explains that memory (*smṛti*) and fearlessness (*abhīrutva*) are important in patients because, in the former, the ability to recall states of health prior to the experience of disease is useful to calibrate the intensity of treatment and to assess recovery. He says that fearlessness is expedient when patients face the painful conditions that accompany acute disease and physical impairment, not to mention potentially uncomfortable treatments or therapies that might be necessary to overcome sickness.[42]

We do not know how the compilers of the Sanskrit classics arrived at the view that life science is built upon the pillars of physician, attendant, patient, and remedies. Surely their own investigations and observations impacted this conclusion. The development and practical teaching and applications of *āyurveda* in the present day are, correspondingly, also situated in particular contexts and histories that support and justify references to this healing tradition as *South Asian medicine*. Even so, the proposition that a tradition of healing, which does not overtly depend on possession or divine intervention, such as ritual or spiritual healing, rests on an equation of physicians armed with medicines for use on people who need it, because they are sick, may also be viewed as broad and basic to most notions and forms of somatic healing that we find around the world. If we strip away variations in professional titles and therapeutic substances that differ from location to location, historical eras, and research developments, perhaps this combination comprehensively captures the core of life science in general.

But what do we make of the attendant in the ayurvedic quartet, the *upasthātṛ*, sometimes translated as "nurse"?[43] Even this pillar could be read less as a uniquely Indian contribution in the conception of medicine than as an important recognition of the complexities of diagnosis and execution of treatment that ensue in most, if not any, healing endeavor. The ayurvedic attendant provides additional healthcare over and above the physician's evaluation, prognosis, and distribution of healing knowledge to patients. In the history of medicine in the west, the occupation of the nurse (derived from Latin *nutrire*, "to nourish") goes back to ancient Greece, where it associated with therapies internal to families and primarily fell under the purview of women (in ancient Greek, the term we translate as nurse is *aderfí*, "sister").[44] Even when a patient presents a routine problem, a disease that is common and easily treated, the fact that the attendant is one of the foundational pillars of India's life science, a mainstay of support to both the patient

and the physician, suggests that the compilers of this tradition understood healing according to a broad view. It bespeaks an awareness of the combined physical, psychological, and emotional disturbance that causes patienthood and accompanies the human experience of illness. It also acknowledges the challenges that physicians confront apropos patienthood, when the technical healing knowledge and language of their training and professional experience must confront not abstracted maladies or anonymous afflicted bodies, but actual sick and ailing people, whose experiences of illness preexist clinical visits and whose agitated mental and physical states can muddle their efforts to understand fully and even respond to patienthood. To promote healing, the medical attendant works in the interstices that naturally form between people—physicians and patients—who come together to address a physical or mental problem, though their meeting is marked by two very different sets of perspectives, experiences, aims, and knowledge bases.

If delineations of *āyurveda* in the Sanskrit classics at the level of the four pillars of medicine lend themselves to broad-ranging or cross-cultural comparisons, we also have good reason to temper any drift toward universalizing with context-sensitive research that pushes us in the other direction, toward culturally and historically specific observations. Case studies from the field of gurukula pedagogy, knowledge exchange, and clinical practice in emergency situations in the preceding three chapters would suggest that even if the existence of people who deliberately strive to realize modes of education and healing from the classical period in their daily work today, people who practice texts of the past in the present moment, are common in many places and times, the particular means they use to achieve wellbeing are also bound to be quite different.

It is true that the attendant-qua-nurse has a long and comparable history in India and the west. But the ways in which the ayurvedic attendant in the classical sources can be seen in contemporary practice are also good reminders that inquiring practical, everyday rehearsals of textual knowledge almost always reveal difference. The attendant points to the social nature of illness and wellbeing in India. As I noted in chapters 3 and 4, it is commonplace in Kerala for partial or entire families to accompany patients on doctor visits. My field notes from Mookkamangalam are filled with case studies of patients with spider bites, snake bites, dermatitis, muscle weakness, impaired vision, pregnancy complications, and numerous other issues. With few exceptions, the patients in these notes were accompanied by one or more people. Though not exclusively or even primarily women, as the ancient Greek *aderfí* was, all of them were implicated in the experience of the patients and invested in their recovery. Many were parents of youngsters, adult children of elderly parents, and spouses and partners. Some were family friends and neighbors. They served supportive roles, as the texts recommend, augmenting the testimony of the sick and adding perspectival depth to the patients' accounts of their illness experiences. Often, it appeared that Biju and Priyankara privileged the statements of the entourage over a patient's own account, and sometimes they had

to because patients were so injured or distressed that they could not communicate their problems on their own. What is more, after the work at the clinic is over, Biju and Priyankara rely on these attendants to supplement their expert care by lending their encouragement to patients to follow their prescriptions.

Context-dependent difference seen in the contemporary practice of classical texts in the gurukula points to distinctiveness at the level of texts and interpretation as well. Even when we observe parallels among the actors and their relationships in ancient Indian and Greek medical sources, for example, it would be an overstatement, as Jean Filliozat warned us in his classic study, to assign one-to-one correspondences at the level of medical theory in each culture.[45] The fundamental ayurvedic model of *tridoṣa*, the body's three "humors," has been one of the most commonly cited examples of Ayurveda's resemblance to the Greek proposition of the four humors, attributed to Hippocrates and developed by Galen—blood, phlegm, black bile, and yellow bile. Apart from the obvious differences in each culture's calculation—and it is worth noting that other less popular and enduring models of humoralism in the west were also put forth that recognized two, three, or five humors—in many ways the ancient theories were similar. The humors were envisioned as semi-fluid substances that explained disease when they were in excess and/or out of place, and health and wellbeing when they were stable and/or appositely located. The qualities of the humors in both traditions were thought to express temperaments and behaviors in people reflective of the kinds of diseases they caused. Although these temperaments and behaviors were understood to be corporeal, they also naturally lent themselves to communication (in nonmedical as well as medical literature) about emotional and psychological states resulting from feelings of physical malaise, agitation, and discomfort.

For all that they might have in common, historical developments in humoral theory in India and Greece (and the west more generally) deviate plenty over time, and differences in medical practice and research in both locations have impacted the ongoing use and acceptance of humoralism in the modern era. Humoral theory persisted in Europe, Asia Minor, Persia, and Arabia long after Galen as a means to explain what happens internally in sick and healthy bodies, pathology and physiology, moods and cognitive-emotional states. It underwent radical revision in the sixteenth century when the Flemish anatomist Andreas Vesalius critiqued followers of Galenic models of the body that were based on the humors. These people, he lamented, failed "to wield the knife themselves," that is, to practice dissection to understand the organization and functioning of the body.[46] Vesalius's commonsense call for a hands-on approach to know and explain the human body, supported by advanced techniques and precise structural depictions, challenged the Galenists' reliance on unverifiable humoral representations to describe how the body works and falls ill.

In India today the theory of the three humors continues to undergird ayurvedic theory and practice. The development of the ayurvedic college drove Ayurveda

somewhat away from the classical anatomy of *āyurveda* in the collection of Suśruta, chief anatomist among the *bṛhattrayī* texts, by positioning the classics within modern biomedical fields of biology, chemistry, and anatomy. The ayurvedic college curriculum did not take up formal courses of study in dissection or reinstitute surgery, although minimally invasive, "surgical-type" practices such as bloodletting via leech therapy (*jalaukāvacāraṇīya*), derived from Suśruta's collection,[47] persist in Ayurveda in India today to treat things like inflammation, anemia, and certain infections.[48] A few architects of the modern curriculum of the ayurvedic college that I discussed in chapter 1 attempted to bring a number of biomedical ideas and designs, from ideas like those expressed in Vesalius's *On the Fabric of the Human Body* and anatomical representations like those displayed in *Gray's Anatomy*, within the ambit of Ayurveda as a way to complement the Sanskritic theories of about somatic functioning and structure that still prevail today.

Some people in gurukula communities of India in the twenty-first century propound histories that connect the literature of Ayurveda to exalted moments in time, usually periods before the arrival of Muslims and Unani in South Asia and long before the British and French and biomedicine. Because the typical gurukula students I met between 2003–2017 in central Kerala were also products of the modern ayurvedic college system, they are also heirs to the political oratory and Sanskrit textual interpretation of people like Bhagvat Singhji, organizations like the Mumbai Vaidya Sabhā, and numerous governmental committees before and after 1947. Even for people who see great value in the knowledge of the Sanskrit classics to treat sick people in the present day, as do many of the people I have described in this book, the life science that we call Ayurveda is not reducible to the Sanskrit medical classics. These sources provide the symbolic structures and processes for how to understand wellbeing, disease, and healing. They describe *āyurveda*. But Ayurveda as an institutionalized tradition is also profoundly cultural and historical. When we talk about this healing tradition in terms of its texts only, we miss the crucial point that Ayurveda has been and continues to be conceived and constructed, historicized and embodied by actors from various cultures, who speak different languages to explain the Sanskrit classics and who have taught and practiced these texts. For generations of ayurvedic practitioners in south India, the Sanskrit medical classics have been, and for Biju and Priyankara and the students at Mookkamangalam in the first decades of the present century they still are, everyday and authoritative instruments that support teaching and exploration about ways to bring wellbeing to those who need it. Over the course of the twentieth century, contrastingly, these texts have been dyed with a great deal of symbolic weight and far less practical utility in the ayurvedic college education.

The gurukula has regularly been ignored in histories of education and medicine in India, despite the fact that it has, until fairly recently, had a central place in the history of Ayurveda and Indian medical education. As this institution endures in selected locations of south India today, the activities and people in them point us

to valuable ways for thinking about how medicine is practiced in modern India and in general. The method of instruction and techniques of clinical care at Shantimana and Mookkamangalam—the practice of texts imparted via mukhāmukhaṃ instruction—underscores the intertwined nature of education and healing in Ayurveda. Vaidya-gurus trained in this manner, and their students, understand their education and healing to be closely aligned with expressions of pedagogy and treatment expressed in the Sanskrit medical classics, and their views of healing and clinical work today offer an applied (and for the vaidya-gurus, typically unspoken) critique of the ayurvedic college curriculum that took shape in the nineteenth and twentieth centuries. This critique will persist and proliferate as long as Biju accepts and educates students, and these students continue to promote gurukula philology in their professional lives and implement the practice of texts in their professional pursuits, further changing Ayurveda as it advances and adapts to new eras and circumstances in south India and elsewhere.