Ayurveda in the Twenty-First Century: logic, practice and ethics
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(... all systems of medical belief and practice are empirically self-confirming. People everywhere live until they die, and they only die once, while in the process of living they undergo numerous illness episodes. In short, a lot of people will recover their health no matter what the specialists they consult say or do, and they will often attribute their recovery to what was done. (Leslie 1988: 79)

In Cambridge, I read Jan Meulenbeld’s article on *dravyagunasstra*[^2]. In Indian pharmacology, *rasa* [taste] is an important indicator of a medicine’s effectiveness. However, because of its subjectivity, taste is not a category in modern pharmacology. When we want to take Indian classical pharmacology seriously, we must turn to the psychology of perception. The apparatus of modern pharmacology can measure the effects of a medicine but cannot experience it. (biochemist, interview, Bangalore, September 2010)

All knowledge systems, biomedicine and modern positivistic science included, create their own limitations because knowledge and practice are contingent upon a specific ontology, gnosology, epistemology and methodology, as well as upon the mores of knowledge communities such as their ethics and social relations. Though in our times positivistic science and biomedicine have come to be entrenched in
the industrial, capitalist mode of organisation and are therefore both technically and professionally advanced, technological proliferation in itself need not lead to greater efficacy; in short, despite growing costs at the production and consumption end of biomedicine, many patients do not get cured. Indeed, at the macro level there is no evidence that the advancement of medical knowledge and technology translates into better cure for patients. The confession of the French father of surgery, Abroise Paré (1510–90), who said that though physicians sometimes cure and often only can alleviate, but always should offer comfort to the ill, is still valid. Though biomedicine has advanced technically, theoretically and in its ability to garner minute information from inside the body since the times of Paré, infectious diseases are on the rise again and the burden of chronic diseases has risen tremendously. Do we not expect too much of biomedicine’s ability to cure? Are we not misled by biomedicine’s advanced technology, the symbolic power radiated by impressive hospitals and research institutes, the omnipresence of pharmaceuticals in the public sphere and the high status of biomedical practitioners in society? Like any medical system, biomedicine has its shortcomings. Medical theories formulate general laws about the structure, cause and treatment of disease but medical practice deals with individual patients (Bode 2009).

Why do I start a chapter that deals with the representation and construction of ayurveda in twenty-first century India with biomedicine? The answer is that in India, as elsewhere, biomedicine is supported by the state and holds superior prestige in society. For ayurveda—as for other ‘alternative’ medicines like homoeopathy and Traditional Chinese Medicine—biomedicine is the other that is alternately admired, emulated and critiqued. Biomedicine has become something like a benchmark for other medical systems. This has led to copying but also to the creation of a competitive edge, because the invention of a marked identity is a way to prevent assimilation by biomedicine. In this chapter, we will look at how a small but interesting section of the ayurvedic practitioners in contemporary India sees their science and practice. Biomedicine often figures somewhere in the background. I will illustrate and discuss this through the example of college- and university-educated ayurvedic practitioners from Pune, Bangalore and Thrissur. I call them authentic because ayurvedic
Ayurveda in the Twenty-First Century

Ayurveda diagnosis, aetiology and therapeutics mark their practice. Though they represent a small minority of ayurvedic practitioners in India, their determination, creativity and vitality make these authentic ayurvedic practitioners more important than their number suggests. They are very different from the mainstream of ayurvedic physicians who use their ayurvedic degree as a backdoor entrance to biomedical practice. This group make up roughly 65 per cent of India’s 600,000 ayurvedic graduates. The next group in size are ayurvedic graduates in government service—approximately 120,000 practitioners. The third category of ayurvedic practitioners consists of 60,000 graduates.3 Though they sell ayurvedic medicines to their patients, they do not accompany these with strict regimens regulating food and lifestyle. Their patients usually expect their ayurvedic medicines to do the same job as biomedical pharmaceuticals though without the harmful side-effects ascribed to the latter. In their practice these physicians freely use proprietary ayurvedic medicines, a class of products whose composition and production process is designed by its manufacturer. In contrast to classical ayurvedic products, these proprietary ayurvedic medicines are not informed by ayurvedic pharmaceutical logic (dravyagunanāstāra) and are not sanctioned by long-term use (Bode 2006). Proprietary medicines often have biomedical disease categories as their target. In contrast, the authentic ayurvedic practitioners who are the focus of this chapter prescribe mostly classical formulas with the objective of balancing *doshas*, *dhatu*s and *malas*. My informed guess is that this group of authentic ayurvedic practitioners number a few thousand, depending on where we draw the line.

AYURVEDIC LOGIC

Contemporary ayurveda has an ambiguous relation with biomedicine. It is the other that is both imitated and critiqued. The ayurvedic manufacturing industry, for example, emulates the biomedical pharmaceutical industry in fields such as marketing strategy and product research. Advertisements and marketing schemes are designed to seduce the consumer into buying ayurvedic products. Research work quoted in product brochures is either done by the largest among the ayurvedic manufacturers or, more often, by government
institutions such as the research councils for Indian Systems of Medicine (ISM) and government-financed institutes like the Banaras Hindu University and ayurvedic colleges. In earlier publications, I have critiqued this research for being epistemologically naive (Bode 2008: 142–59). Research is guided by a positivistic paradigm and ayurvedic concepts and notions are converted into biomedical ones. Examples are the conflation of the seven *agnis*—the ‘fires’ that are instrumental in the production of healthy ‘tissues’—with enzymes, the uncritical linking of the *doshas* with neurohormones, and the interpretation of *ojas* into the idiom of the biomedical notion of immunity. Research is largely insensitive to ayurveda’s heuristic and interpretive style of knowing. This exercise, exceptions aside, shows a lack of inter-scientific sensitivity (Leslie 1992; Shankar and Manohar 1995; Bode 1998; Meulenbeld 2008). Ayurvedic research driven by biomedical categories has been carried out for the past four decades by scientific teams of the various councils and research institutes. Non-Ayurvedic scientists are the backbone of these teams. Even the leaders of these institutions agree, off the record, that this kind of research has not led to the growth of ayurveda’s clinical and theoretical corpus.

There have been other observations though on the relationship between ayurveda and biomedicine and positivistic science. For example, the American medical anthropologist, Jean Langford, who studied ayurvedic clinical practices in India, argued that the ayurvedic physicians she came across reinterpreted biomedical notions and practices in an ayurvedic way. They worked the other way around and their act of reinterpretation resulted in the encapsulation of biomedical substances, notions and practices by ayurveda (Langford 2002). It seems that the city-based ayurvedic practitioners who are the focus of Langford’s writings took a more assertive stand towards biomedicine than researchers working for large ayurvedic industries and government-financed research institutions. The situation is different again in rural areas where vaidyas have managed to retain their clientele and autonomy. Here, the inroads of biomedicine seem to be minor (Shankar 2004; Sujatha 2007, 2009).

However, the ayurvedic practitioners who are the focus of this article are different from the above-mentioned cases. My informants are very well qualified in ayurveda in the modern institutional sense
of the word and practise ayurveda in the most authentic way possible within the constraints posed by their historical and institutional location. Contemporary realities of biomedical dominance and power force them to react to biomedicine and to the positivistic paradigm of viewing disease. An ayurvedic MD who is currently designing a check-up for the heart by linking ayurvedic health parameters to biomedical ones reacted as follows to my question about the concurrence of ayurvedic and biomedical logics:

Look we cannot wish away the fact that nowadays allopathic diagnostics is the mainstream. It is widely prevalent as the way to know one's health. I use ayurvedic parameters to assess the lifestyle deviations from the classical texts which mention thirteen natural urges one should not suppress, of which nine are linked to heart disease. Then, I use modern medicine to monitor the outcome of ayurvedic diagnosis and treatment of heart disease. But allopathic parameters are not a variable for heart interventions based on ayurveda. (Ayurvedic Physician 1, interview, Bangalore, September 2010)

At least in Indian cities, patients often confront ayurvedic physicians with biomedical diagnosis. This reflects the social acceptance of biomedical logic and the fact that ayurveda is regularly used as secondary resort after biomedical treatment has failed. When I confronted another ayurvedic physician with this state of affairs he told me that he hardly took notice of biomedical test reports because:

Our disease categories differ from allopathic ones and often an allopathic diagnosis brought by a patient is not useful for ayurvedic treatment. It is not practical for me to know that a patient has, for example, typhoid. I have to decide his condition on the basis of dosha, dhatu and agni. When the disease is not mentioned in the ayurvedic texts I can still treat the patient according to the morbid doshas and dushyas; and the sthana where the disease has manifested in the body. Then I look up the cikitsa sutra of one of our classic texts. My treatment will depend upon the state of a patient’s dosha, dhatu and agni. If the same ailment occurs more often in my clinic, then I will try to develop a standard treatment for it. But even if a disease occurs only once it is not a problem.
Maarten Bode (MB): But do patients not cling to their allopathic test results and do they not want you to treat them accordingly?

Yes, this often happens. Let me give you an example. I took a patient whose sugar level was above 200 and did not come down despite dieting. The patient thought he felt better, but he wanted me to bring the level down. However, I diagnose and treat in my own way. Maybe my strategy makes the sugar come down but that is not the objective of my treatment. So I asked this patient: “Do you want these numbers or your disease corrected? Do you want me to put right your reports or your disorder?” (Ayurvedic Physician 2, interview, Pune, April 2009)

Compared to biomedical test results which are measurements by machines, ayurvedic parameters are closer to how patients experience their ailment. Ayurvedic structuring of illness representations remain closer to the sufferer. In the next quote an ayurvedic practitioner, who also teaches ayurveda and publishes ayurvedic books, explains why this is so:

Ayurveda deals with the logic of responses and modern medicine with the logic of reactions. Laboratory science is the analysis of reactions but clinical science deals with responses. I will give you an example. Ayurvedic diabetic medicines were given to rats in a laboratory experiment. The rats did not respond to the medication. But our ayurvedic medicines are for humans. When we would give them to, for example, rats, we would have to make modifications. When you kick a dog, the reaction will not change. In any social-political and cultural situation the dog’s reaction will be the same. You can kick the dog a hundred times and the reaction will be the same. But patients have their individual responses to medications and treatments. To take this into account makes the difference between oriental medicine and science, on the one hand, and western medicine and science, on the other.

M.B.: Indeed, humans are conscious of things they do...

Yes, we can tell a diabetic patient to do this or that but you cannot tell rats anything. Every physician has to go from lab findings to clinical
findings. I am sure individual physicians of modern medicine will find many differences between their practice and what lab science tells them. Allopathic colleagues who use medicines in the treatment of heart and cancer patients tell me: “Yes, these medicines have side effects that are not mentioned in the lab reports.” A moment ago, you asked about the claims of ayurveda in case of medicines like lauh bhasma and shankapuspi. These medicines should be judged by ayurvedic researchers, not by modern medicine researchers. In ayurveda, we deal with responses, not with reactions, so there should be a totally new way of assessment of the effects of medicines. We believe in assessment. When we deal with living things then in your Amsterdam you say that reactions will be very similar but in India we actually believe that everyone has his own “Sa” [a tone in Indian music]. We have our assumptions, beliefs and values—whatever you call them. We believe in moksha, atma-consciousness, and karma. Like Indian games and Indian music, our medicine has its own logic. Our music and our history are cyclic. In traditional Indian games, we do not have a knock-out system. There is coming and going of the players. It is cyclic—one time you are out, another time you are in. Your football is very different. Once you are out, you cannot come in again. It is similar with our medicines. Their qualities are not absolute but depend upon the person who takes them. Every science has assumptions of its own. The problem with the dominant western worldview is that this is not seen any more. (Ayurvedic Physician 3, interview, Pune, March 2009)

This ayurvedic practitioner-cum-educator responds to the fact that ayurveda has its own style of knowing. As a heuristic practice, ayurveda deals with meaning and individual experience. In ayurveda’s approach to reality, the observed and the observer, the response and the one who reacts, are not as rigidly separated as in positivism. Ayurveda’s approach is not necessarily linear and unicausal but links dimensions of human life such as body, mind and ecology, which positivistic science keeps separate, as the next quote testifies:

For me, knowledge of biology combines science and philosophy. For example, atma is represented in the body by agni. If agni is dead, man is dead and becomes a physical entity instead of a biological one. When the five mahabhutas come together with atman, agni
and jeevan we get the living person who is the subject of treatment. The ayurvedic theory of the gunas tells us that the metaphysical entities—rajas, tamas and sattva—have no form but only qualities. Gunas have no life by themselves but they can form anything in the material world. Manas or mind is on the boundary of atman and the panchamahabhutas. The intermediate level of mind is influenced by food. For example, sattvic food can mitigate the faults of the mind such as tamas and rajas. (Ayurvedic Physician 4, interview, Pune, April 2009)

Ayurveda’s perspective on body and mind seems to view them as lying on a continuum and accords more with human experience than biomedicine’s notion that body and mind are dichotomous.

AYURVEDIC PRACTICE

Biomedicine has a preference for technical and objectifying diagnostic practices which convert individual patients to exemplars of a disease class. Somatic and behavioural dysfunctions are preferably explained by deformities and irregularities which modern technology can objectify. Biomedicine explains disease from “increasingly deeper layers of materiality” such as the organ, the cell and the gene (Good 1994). Coming up with a disease category is more important than explaining why a particular patient feels unwell. The lens is on ‘what’ not on ‘why’. In contrast, ayurvedic diagnosis is less fine-tuned when it comes to well-delineated disease categories. Ayurveda has its broadly-defined disease clusters instead. My ayurvedic informants repeatedly told me that ayurvedic physicians should not at all be ashamed if they cannot name the disease a patient brings to them because the texts state that diseases are uncountable. For them, giving time to the patient and explaining why the patient feels ill are their strong points. One of my informants put it like this:

You must know the cause of the visha [impurity, toxin] causing imbalance and therefore the disease. You must know a patient’s individual hetu [deviation from the regimen]. What makes this particular patient ill? For example, when lack of sleep has increased
a patient’s *tamasvata*, I must know this. It is not sufficient to know that he suffers from dullness and nervousness. If the individual disease cause is unknown, ayurveda cannot treat it. Our treatments are strategy-based, not disease-and-drug-based like those of allopathy. The drugs and regimens we use depend upon the age of the patient and the season in which a treatment takes place. Drugs, regimens and therapies might vary, but the disease strategy itself does not change. (Ayurvedic Practitioner 4, interview, Pune, March 2009)

According to this MD (Ayurveda) in his thirties, ayurveda focuses on violations from what suits an individual, for example, on deviations from what adheres to him or her (*satmya*). The determination of *hetu* must be followed by designing a tailor-made treatment strategy (*upakarma*). This physician further emphasised that ayurvedic treatment strategies are designed on the basis of assessing the imbalance between the *pancamahabhutas* (earth, water, fire, wind and space); where the disease is located in the body (*sthana*); and the state of the patient’s digestive fire (*agni*). For the treatment strategies he referred a section in the Caraka Samhita where the six *upakarmas* are mentioned and described (Sharma 1981: 150–3). According to him, this approach is to be preferred because the rigidity of biomedical diagnostic practice can block appropriate treatment. He illustrated and explained this with the help of the following case description:

During 2004–8 I treated a Christian woman from Kerala. She had been given a range of allopathic diagnoses and treatments. First, they diagnosed her with deficiency of thrombocytes in the blood. Though the platelet count was very low, this did not correspond with the severity of her symptoms. In the same period she was also diagnosed as having calcium shortage, TB and SLE, an autoimmune disease. But allopathic treatments based on each of these diagnoses did not work. When she came to me she was just married and bled continuously for seven days when she had her period which lasted for ten days. She also had bleeding gums, and patches on the knees and thighbones. She was put on Vasalon 60 mg [a cortico-steroid] for a year. Her *doshas* were severely vitiated. She had a *pitta-vata* problem. Over a period of four years she regularly followed *pancakarma* procedures
such as *virechan* (oral purgation) and *basti* (anal purgation). I got her off the Vasalon which masked her disease. Then, symptoms like leg pain, night itching, bleeding gums, and black stools, came to the foreground. Consequently, I changed the medicines and prescribed *kashayams*. But I regularly adapted the medication, especially during change of seasons. For example, it was in August 2004 when the rains were heavy that she got severe pain in the shoulders. In the rainy season, *vata* often increases and I had to pacify *vata* accordingly. In April 2005 and April 2007, her symptoms got worse again which made me change her medications accordingly. On 25 December 2008 she had her second child, a baby girl. She is much better now, but remains under my treatment. (Ayurvedic Practitioner 4, Pune, April 2009)

We can read this case as an example of ‘medicine answering’ in which a patient’s illness perception guides treatment (Nichter and Nordstrom 1989). As I have stated before, at least in Indian cities ayurveda regularly functions as secondary resort and as an alternative way of treatment after biomedical treatment has failed. A recent empirical study done in Mysore confirmed this impression (Nisula 2006). Another recent study, in Bangalore, showed that biomedical diagnostic procedures are deployed to confirm that ayurvedic treatment has had a positive outcome (Naraindas 2006). That ayurveda’s subordinate status in India as a form of Complementary and Alternative Medicine (CAM) is not accepted by everybody is illustrated by the following quote:

Ayurveda was called a tradition, suggesting something of the past, and now it is called an alternative system of medicine. This latter description we hate. We know from history that till 1680 there was no other system of medicine in India and ayurveda was used from Kashmir to Tamil Nadu. Nowadays, many Indians also see ayurveda as CAM. Even if they practice ayurveda, they think it is only for certain conditions. In my clinic, we have started indoor facilities to expand the scope of ayurveda. For example, kidney stone patients think that ayurveda might be able to get the stones out, but for painkillers they must to turn to allopathy. However, we have recently shown that we too have ayurvedic treatment for the pain that comes
with kidney stones. It is not possible for us to treat every disease, but we have made a start and will gradually expand our facilities. At the moment, we have a 24-hour facility and many difficult cases have been treated here. (Ayurvedic Physician 2, interview, Pune, April 2009)

AYURVEDIC ETHICS

‘One man’s illness should not be another man’s celebration’, I was told in 1996 when I started my research on the ayurvedic industry. This remark reflects the representation of ayurveda and its practitioners as redeemers of physical and mental suffering. Ayurveda is said to advance somatic, social, psychological and spiritual well-being, and in the public sphere and advertising ayurveda often becomes associated with non-violence. Propagators of ayurveda see the medical tradition as altruistic, natural, gentle, nourishing, and ecologically sound (Bode 2008: 173–96). However, ayurvedic medicines and practices are also objects of trade shaped by the logic of commerce. In the last part of this chapter, we will see how ayurvedic practitioners look upon the commodification and commoditisation of ayurveda. The following two quotations point out, as well as critique, ayurveda’s commercial turn.

Commerce makes ayurveda unaffordable and threatens the affordability of ayurvedic medicines and the availability of ingredients. The price of amla has gone up from Rs 5 a kg to Rs 50 a kg. Amla is the main ingredient of chyawanprash, but there is more chyawanprash in the market than there is amla available in India. A jar of triphalachuran for which you formerly paid Rs 10 is now offered for Rs 70. The industry markets many so-called ayurvedic cosmetics but ayurveda sees beauty as a thing that comes from the inside, from the making of excellent dhatus. (Ayurvedic Physician 5, interview, Bangalore, September 2010)

Dabur says that taking their chyawanprash will raise your immunity and that they know how to make it because they have over hundred years of experience. Nowadays, chyawanprash has become a health
tonic or a jam to put on toast when you have breakfast. This gives a bad name to ayurveda. It creates the idea that this product is ayurveda but that is not the case. Originally ayurveda was an approach. Now the product is what is considered to be ayurveda. But there are no ayurvedic products, only material substances that can be used ayurvedically. (Ayurvedic Physician 6, interview, Thrissur, September 2010)

The message here is that a good ayurvedic physician can apply everything as a medicine. But it is a misnomer to call a product ayurvedic because only its deployment makes it so. The last informant also pressed the point that ayurveda’s commodification and commoditisation has turned many ayurvedic physicians into mediators between manufacturers and patients. To this he added that

(...) ideally ayurveda is seva [service] but we live in commercial times and vaidyas are part of this. The public also puts pressure on ayurvedic physicians when they demand readymade medicines prescribed without too many food and lifestyle restrictions. We want everything readymade. Just as with food. In the past, people would prepare it themselves but now they get it from a hotel. (Ayurvedic Physician 6, interview, Thrissur September 2010)

This practitioner argues that the commodification of ayurveda is contrary to its essence. Ayurveda, he says, emphasises that health follows from a balanced, sober and disciplined life—a life in accordance with regimen (pathya) laid down in ayurvedic canons. In this sense, ayurveda is a moral enterprise. Illness comes from violating the rules for a wholesome life. Sick people are in a state of vikriti which means “distortion”, “defect”, “mutilation”, or “impairment”. Ayurvedic treatment aims at guiding the patient back to his natural state (prakruti). Here, disease is not an aspect of nature but a sign of the violation of the rules of nature. Eventually, disease is a perversion. The focus is more on health than on disease. Central are guidelines for leading a ‘wholesome’ life in accordance with satmya (that which adheres to one) and with the aim of becoming svasthya (established in oneself). When bodily order has been restored, the body’s self-healing capacity automatically returns. And it is this self-
healing capacity ayurveda wants to address. It considers the taking of medicines as a subordinate therapeutic measure. Instead, ayurveda cautions against nutritional imbalance, as also against stress and emotional imbalance. One of my informants put it like this: “My guru, Raghavan Thirumulpad, often recites a Sanskrit sloka which, in translation, goes: ‘for a person who follows pathya what is the need of medication and for the person who does not follow pathyas what is the use of medication?’” (Ayurvedic Physician 1, interview, Bangalore, September 2010). In ayurveda, the word pathya (regimen) refers to disciplining one’s sense organs to which, in line with Sankhya philosophy, the human mind also belongs. According to authentic ayurvedic practitioners, mental tranquillity together with right food habits and disciplined behaviour is a surer way to health than taking medicines. The notions that food is medicine and medicine food, that health is a many-sided equilibrium (samya) and the representation of human life as consisting of stages with expectations and possibilities of their own (varnashrama), lie at the heart of Indian medical traditions (Wujastyk 2008; Bode 2008; Valiathan 2009). This brings us to the much-debated relationship between medicine and culture.

MEDICINE AND CULTURE

Linking up medicine and culture can be controversial, because the term ‘culture’ has been associated with local, parochial and faulty medical knowledge. This conflation can become a strategy for those who want to depreciate medical systems other than biomedicine. In this rhetoric, Indian medical culture is easily accused of preventing people from accessing rational and effective health care, and high mortality and morbidity rates are blamed on Indian medical notions. In the same way, Indian medical culture has been represented as tainted by superstition and labelled as ‘unscientific’ in the sense of harmful and false. Connecting medicine and culture can depreciate medical systems other than biomedicine which is then wrongly considered to be free of culture (Young 1982; Franklin 1995; Habib and Raina 2005; Bode 2008).

However, this does not deny that ayurveda as a medical system shares a cultural universe with its patients which can be an asset for
successful medical treatment. Here, expert medical knowledge finds common ground with the cognitive universe of patients. Sharing the same cognitive universe can facilitate treatment. This is illustrated by the next case study, which describes the logic at work in the treatment of numbness in the legs by a vaidya who runs a home-based practice in rural Tamil Nadu (Trawick 1992).

Dr Iyer is an 85-year-old vaidya who has a home-based practice in rural Tamil Nadu. The patient is a 60-year-old illiterate woman who has come to Dr Iyer for numbness in the soles of her feet. A lengthy conversation develops, which can be described as a directive form of advising. Iyer argues that the senses (indriyas) are weakening as part of growing older. The tactile stimuli that should bring life to the patient’s feet are feeble; Iyer talks about a weak connection between the skin and the flesh, which he attributes to ‘obstructed’ blood that is poisoning the body. There are ‘flow blockages’ in the srotas that transport blood and waste products and in the transmission of external sensory stimuli. Iyer believes that the nerves of the brain, eyes, ears, nose, tongue and skin are losing their strength. Undigested food (ama) and poisoned blood are undermining the body. He prescribes an oil to slow down the decline of the sensory nerves caused by the patient’s age. The oil must be applied before bathing and then rinsed off with warm water. He also prescribes a medicine to maintain a feeling of hunger, to allow the faeces to ‘flow’ after a meal, to separate the urine from the faeces and to make the body ‘light’.

Iyer sees the patient’s symptoms as a disruption in vata, a consequence of ageing. The medicines are for support only and Iyer makes it clear that ‘suitable’ food and ‘appropriate’ behaviour are more important for healing than the medicines he prescribes. He forbids ‘heavy’ food because this ‘coagulates’, causes dullness, and leads to numbness in the limbs; advises against eating tamarind, which makes a person listless and drowsy; and stresses the need to eat ‘suitable’ (satmya) food regularly and in moderation. According to him, flow blockages obstruct the formation and movement of dosha, dhatu and mala and therefore life processes stagnate. He emphasises the connection between movement and life and repeatedly states that the patient’s symptoms come from ageing. He advises her not to frequent busy markets and instead recommends outings into nature and visits to temples. Iyer places the illness in a metaphysical
context. For this, he makes use of cultural categories and constructs a framework in which to place life–illness–suffering–death. Just as the formation of body tissues (dhatu) is linked to ‘purification’ and release of the essence, the ageing body goes through a process that leads to death and the release (moksha) of the soul (purusha) from the material body (prakriti)—a logic based on Hinduism and the related Sankhya philosophy.

This example illustrates that Indian notions which can be traced back to Sankhya philosophy—one of the six Indian systems of philosophy—give meaning to suffering and offers a strategy to deal with the same. Here, philosophy works because the ethos is shared by patient and physician. In the perspective of symbolic anthropology, medical systems—whether lay or expert, global or local—convert the signs of disease into socially significant and collectively-accepted outcomes. In this sense, all medical systems are cultures which provide us with a model of, and a model for, naming, explaining and treating somatic and behavioural dysfunctions.

We now look at the medical system of an Indian religious sect, the Kin Ram Aghori, to illustrate that—at least in this example—taking cultural representations of a disease like leukoderma (vitiligo) seriously can be at the heart of effective medical treatment (Barrett 2008). Interviews with both sufferers and the general public in Varanasi such as shopkeepers, market vendors and students, showed that many see skin diseases such as leucoderma and leprosy as testimonies to an unethical lifestyle, lack of hygiene and poverty. The manipulation of the key Indian metaphor of impurity is central to the Aghori treatment of these stigmatic skin diseases. The treatment consists of somatic and mental purification with the help of ayurvedic medicines and, equally importantly, the removal of the “mental impurities” that are seen by the Aghori therapists and their patients as the root cause of leucoderma and leprosy. The Kin Ram Aghoris’ state of ritual purity enables them to function as a dumping ground for mental pollutions. The analogue is provided by the holy river Ganges which, according to Hindu logic, absorbs and neutralises all kinds of sins, transforms mental and somatic impurities and leads people back to cleanliness and health. The healing ceremonies that are at the heart of Aghori treatment of dreaded diseases are powerful antidotes against the biosocial illness of discrimination which is in
the case of leukoderma more debilitating than its somatic counterpart in the form of white patches on the skin. Here, treating the stigma is crucial, because the dreaded character of leucoderma and leprosy heavily determines the epidemiologies and trajectories of these skin diseases. Leucoderma especially is harmless in a somatic sense and biomedical drugs can effectively treat the bodily aspects of leprosy. Dealing with social stigmas and individual perceptions of ill-famed diseases—patients commonly internalise social prejudices—is also crucial when it comes to treating other dreaded diseases such as tuberculosis and HIV/AIDS. Stigma adds to the suffering of patients because it induces shame and consequently can obstruct treatment. The examples given show that sensitivity to local meanings is a must for successful medical treatment.

The examples from Tamil Nadu and Varanasi show that the sharing of a cultural universe by patients and medical practitioners can be crucial for productively treating diseases. However, we must not turn this argument around and assume that patients and practitioners must share the same cultural universe for medical treatment to become effective. This would ignore the fact that empirical research shows that the medical beliefs of patients are highly flexible. Cultural reinterpretation of medical materials, notions and practices is a common state of affairs. To illustrate this, I want to present the reader with three examples. My first example brings us to Calcutta of the 1980s. Patients with mental problems consulting a modern psychiatrist who attributed their disease to mental shock reasoned that this shock must have undermined the hot–cold balance in their bodies. They therefore did not see any contradiction between their humoural reasoning and the perspective of the consulted psychiatrists (Bhattacharyya 1983). Another researcher went one step further and introduced the notion of ‘misunderstanding as therapy’ to describe that though patients used the ayurvedic notion of imbalance to explain their disease they did not see any contradiction with the biomedical pharmaceutical regime prescribed to them by biomedical physicians (Sachs 1989). Common logic also explains why the therapy management group of a young Sri Lankan woman with severe mental problems who was subsequently taken to an ayurvedic practitioner, an exorcist and a modern pharmacist, did not become bewildered when confronted by three very different paradigms.
They did not experience incompatibility because they considered all three logics to “phrase illness most basically in terms of excess and imbalance” (Amarasingham 1980). The three explanatory models for explaining the young woman’s suffering were encapsulated by the South Asian notion of *samya* (many-sided equilibrium). Therefore, patients and their relatives did not suffer cognitive dissonance when confronted by three logics for explaining the same ailment.

**CONCLUDING REMARKS**

There are diverse rationalities and multiple realities in the naming, understanding and treatment of disease. The importance of CAM in today’s world can be interpreted as proof of the fact that not a single medical system can claim solutions to every form of somatic and mental suffering. Medical cultures look through the lens of their own categories and therefore apply their own logic when they name, explain and act upon disease defined as somatic and behavioural dysfunction. The chapter described and analysed the reinvention of ayurveda by a select group of mainly young ayurvedic practitioners. Consumer society and biomedical dominance is the context in which ayurvedic diagnosis and therapy are applied clinically today. By tapping into Indian philosophy and culture, the authentic ayurvedic practitioners studied in this article made sense of individual suffering and motivated patients to take responsibility for their ailments and treatments. Health is seen as a multi-sided equilibrium and understanding the synchronicity of causes on the individual level provides the treatment rationale. What I have labelled as an authentic ayurvedic approach looks upon the patient as a conscious being who lives his or her disease and gives meaning to treatment by the way he or she responds to it. I argue that this personal methodology primarily treats the diseased and not the disease. This is in line with the fact that patients are not passive objects but subjects who live their disease in a visceral, cognitive and social way. In their treatments, the authentic ayurvedic practitioners who were the focus of this article went beyond the biomedical definition of disease and analysed somatic and behaviour dysfunctions as lived phenomenon. The intersubjective nature of ayurvedic concepts such as *rasa* (taste), *prakriti* (constitution) and
svasthya (health) is an asset when we realise that medical practice deals with individuals. The structural and cultural dominance of biomedicine and its style of knowing has lead to undue—in the sense of not proven—claims of its epistemologically superiority and greater efficacy and efficiency, which is largely assumed rather than proven conclusively. Is it not by definition impossible to judge logics against each other because each of them represent a different perspective on the phenomenological world of the signs of disease? In the twenty–first century, the logic, practice and ethics of authentic ayurveda offers a distinct way of conceptualising, explaining and treating somatic and behavioural dysfunctions.

NOTES

1 The article is dedicated to the memory of Charles Leslie who died on 15 August 2009. For forty years, Charles Leslie had been the driving force behind the study of Asian medical traditions as social institutions. He organised conferences, founded the book series ‘Comparative Studies of Health Systems and Medical Care’ (University of California Press), and served as its general editor for fourteen years; and for twelve years he was the Senior Editor of the Medical Anthropology section of that truly international journal, ‘Social Science and Medicine’, a periodical read by social scientists in many disciplines. In addition to all this, he helped many young and not-so-young scholars establish their careers. He was also one of the founders of the International Association for the Study of Traditional Asian Medicine (IASTAM).

2 The ayurvedic science of the medical properties of material substances.

3 The numbers and percentages are no more than educated guesses; they are based on the website of AYUSH, Wujastyk and Smith 2008, and my interviews with leading ayurvedic practitioners in India.

4 Actually, there are three pairs: reducing–nourishing, drying–lubricating, moistening–contracting.

5 I distinguish between ‘commoditisation’ and ‘commodification’. ‘Commoditisation’ refers to material things as objects of trade and I apply the term ‘commodification’ to indicate that a money tag has been put on non-material things such as healing practices.

6 See Leena Abraham in this volume.