Disease, Religion and Healing in Asia

Collaborations and collisions

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6 Storytelling and accountability for illness in Sanskrit medical literature

Anthony Cerulli

In Sanskrit medical literature, the ways in which and the reasons why people become sick are sometimes explained with stories. These stories, or illness narratives as I often refer to them here, are typically variants of mythologies found in the Vedas, the *Mahābhārata* and *Rāmāyaṇa* epics, and the Purāṇas. In the Sanskrit sources of Āyurveda, one of India's classical medical systems, these stories constitute a unique type of explanatory model. They not only offer reasons for the occurrence of sickness and suggest possible treatments, as standard explanatory models of sickness in Āyurveda do; they also give meaning to the personal and social experience of being ill. The ayurvedic "patient" – identified in Sanskrit as *rogin*, *ātura*, or *vyādhita*, each of which means "diseased (one)" or "suffering (one)" – receives special attention in these stories not seen in the non-narrative portions of the ayurvedic compendia. The tradition's illness narratives tend not to focus on the inner workings of human bodies, issues that in a modern biomedical idiom would fall under the fields of anatomy and physiology, as much as they address the lived experiences of patients. The decisions patients make and the actions those decisions lead them to undertake take on particular importance in these stories. As readers of illness narratives in the Sanskrit medical texts, we are confronted with common aspects of the social and moral dimensions of human life, which lead to the question: How did the compilers of the illness narratives arrive at determinations of what it means to be a patient in Āyurveda? In these stories, we find that notions of health and illness quickly move beyond questions of physical form and internal bodily function, and that they address issues of the body that contribute to social ethics and religious practice. For the compilers of the Sanskrit medical sources, the narrative explanatory model appears to have been a device to portray, echoing Susan Sontag's trenchant phrase, illnesses as metaphors for certain social and religious expectations. They reveal cultural anxieties about mortality and the human condition, specifying "an ideal of society's well-being" while simultaneously imputing guilt onto individuals and prescribing discipline.¹

In this chapter, I discuss some of the ways that medical narratives in Āyurveda's classical literature may be read as explanatory models. I present a case study from the *Carakasaṃhitā*, a foundational ayurvedic text written

around the turn of the Common Era, to explore the ways in which medical narratives deploy morally laden rhetoric to suggest patient accountability for illness. The case presented here illustrates well how the compilers of ayurvedic literature reclaimed stories about the body often told in religious texts, tales about ritual activity and ethical relations, and retold them with uniquely medical variations. In general these stories contribute both moralistic and medical information about the body, health, and illness, addressing matters as ordinary as fever, as we see below, and biophysiological troubles as devastating as miscarriage, and they link these corporeal misfortunes with such things as improper Hindu devotional worship, purity/pollution, and marital infidelity.

Explanatory models

Explanatory models in medicine are used to spell out why and how certain phenomena related to health and sickness are the way they are. Researchers of numerous subjects, physicians, and patients use explanatory models of one sort or another to explain the various stresses a body undergoes when it is saddled with disease. To be sure, people explain sickness and disease in a multitude of ways. But whatever the focus – for example, the molecular, physiological, or social causes of disease – explanatory models of sickness typically elucidate similar things. Arthur Kleinman has suggested that explanatory models in the medical context attend to five areas: [1] etiology, [2] onset and type(s) of symptoms, [3] pathology, [4] severity of sickness, and [5] treatment.² Doctors and patients attempt to make sense of sickness somewhere amid these five areas, often putting emphasis on one or more areas depending on the issue and cultural context.

As an explanatory model, the illness narrative primarily addresses *illness* rather than *disease*. With this differentiation I want to stress a concern with the psychosocial and cultural implications of being sick – illness – as opposed to the strictly biophysiological characteristics identifiable on an ailing body – disease. In Āyurveda's Sanskrit classics, a decidedly non-narrative type of explanatory model prevails. Whereas in illness narratives we meet patients in the course of stories with beginnings, middles, and ends, patients whose experiences of illness are imbricated with conceptions, views, social relationships, and actions, the tradition's non-narrative explications of disease side-step the question of a patient's lived experience. The diseased body is treated with syllogistic economy, according to symptomatology and foundational theories like the well-known doctrine of the three humors (*tridoṣavidyā*). The full life of the patient, her interpersonal relationships, and the ways in which she has used her body in the world are generally not considered.³ The illness narratives, in contrast, read like social histories. In them the topic of disease is a literary vector with which the compilers of the tradition communicate the cultural values and norms of their particular demography and historical time.⁴

A careful reading of the ayurvedic classics suggests these compendia were composed primarily for students-in-training and educated ayurvedic

physicians, known as *vaidyas*. A good deal of work remains to be done concerning the frequency with which *vaidyas* historically used illness narratives in the Sanskrit medical classics with their patients. Notwithstanding that, literary critical analysis reveals the narrative explanatory model – storytelling to relate the occurrence and cause of illness – to be a compelling and complex part of Āyurveda's Sanskrit corpus that merits philological attention and investigation. These narratives draw upon, contribute to, and conceptually bridge an array of premodern Indian knowledge systems. That they manage to do this without rigidly compartmentalizing Indian culture into independently discussable institutions of medicine, religion, politics, economics, education, and so on, challenges the modern application of non-Sanskrit (or "non-ayurvedic") technical terms to historicize Āyurveda. Where, for example, we might be tempted to read a "religious" or "moral" influence in the text, or expect to find a "medical" analysis, we might come closer to the meaning of these texts by dropping the categories ready at hand and adopting the multilayered sociocultural view of health, illness, and the body promoted in these narratives. This is perhaps easier said than done; it is not uncommon for the modern scholarship on the history of ayurvedic medicine to devolve into an exercise in parsing the so-called medical from the religious layers of the foundational Sanskrit literature.

In the twentieth century a number of practicing *vaidyas* and medical historians held the position that Āyurveda is a "pure science," oft-identified by the Sanskrit moniker of *śuddha āyurveda*, which at times throughout India's history became sullied with ideas and methods of an irrational or religious nature. The purported original medicine of Āyurveda on this view can somehow be distilled from discourses in the literature considered to be non-medical or non-empirical. One could cite many arguments in this regard, including publications that in effect attempt to divorce from the history of Āyurveda perceived marks of non-empirical and unscientific methods. A standard proposal was to view "religious influence" in the Sanskrit medical classics as the result of an imposition from outside of Āyurveda by Brahman priests who attempted to annex the knowledge system within their sphere of influence.⁵ Modern promoters of this view often try to position Āyurveda as a "medical system" alongside global biomedicine, and they insist on exploring the classical Indian knowledge system apart from other cultural institutions in Indian history. This line of argumentation uncritically presumes that the compilers of classical ayurvedic literature were uninterested in the intellectual and material associations of their own questions about the body and things like ritual practices, agriculture, politics, economics, and social perceptions of disease. In choosing to read the narratives of Āyurveda as an integral part of this tradition's history, a part that often involves questions of social, legal, and religious duties (*dharma*), I deliberately elect to recognize, analyze, and interpret the place of ayurvedic discourse – questions and commentaries about the body, illness, and wellbeing – in Indian cultural history. And while the compilers of the tradition, who composed and redacted the Sanskrit classics, will

forever remain anonymous, the onus is on us to receive their work as we have it today, not to explain away portions or to privilege some parts over others. Āyurveda is a composite knowledge system that deploys multiple methods of argumentation and explication. Acknowledging this necessarily muddies attempts to classify Āyurveda in terms of the modern categories of medicine and science. Such an acknowledgement furthermore insists that we read the ayurvedic sources with an eye on the compilers' attentiveness to, interest in, and critique of the historical and cultural processes at play when their texts were produced. Inquiries into and considerations of social ethics, religion, ritual practice, legal propriety, sexual behaviors, urban and rural topographies, occupations, and more are therefore carefully considered in view of the classical compendia's representation of the human organism.

With respect to storytelling specifically, in my fieldwork in south India I have met *vaidyas*, students, and scholars of Āyurveda who cannot (or choose not to) make heads or tails of the narrative parts of the Sanskrit medical classics. Their reasons are usually pragmatic. With no apparent use for the stories in their day-to-day clinical practice, for example, some *vaidyas* find it easier not to put too much stock in these sections of the medical sources. All the same, an interest in the stories of Āyurveda also appears to persist, notably among researchers whose work involves frequent direct readings of the Sanskrit medical classics. It is an interest fraught with ambiguity, however, about how to square what are, on the one hand, seen as literary innovations within the medical texts and, on the other hand, what is perceived to be material that critics of Āyurveda or practitioners of competing medical systems might cite as the "soft" or "spiritualized" nature of this medical tradition.⁶ Seen as archaic religious relics that hold little purchase on the modern application of Āyurveda, the tradition's illness narratives have been routinely dismissed by *vaidyas* and scholars alike as unnecessary to explain, much less understand, the tradition. This is a historically selective view of the literature, which refuses to see the potential unsuitability of the terms "medicine" and "medical systems" in the study of Āyurveda. As we attempt to understand the history of Indian medicine, the texts are often the primary sources we have to interpret both the place of the body and its care in Indian cultural history and the long and lasting impact – literally the collaborations and collisions – that the numerous cultural institutions in Indian societies have had in the development of Āyurveda. It is important therefore to read the texts *in toto*, conscious of the many accretions and redactions these sources underwent before they reached the state in which we have them today. We may then judiciously discuss these works as part of a *tradition of healing*, which we may or may not wish to call "medical" and which, conceivably, might not neatly match up with the notion of a "medical system" in the modern idiom of global biomedicine.

The Sanskrit literature of classical Āyurveda in many ways presents a more comprehensive ambit of interests than the term "medicine" in modern biomedical parlance denotes. When we read the Sanskrit medical classics, therefore, it is naturally critical to read them as commentaries on the

body, its structure and functioning. But we ought to also press further and try to understand the parts of the texts that for a long time have been brushed aside as "unmedical" interpolations. The complex coming together of multiple knowledge systems in the ayurvedic sources indicates a broad cultural interest and investment on the part of the compilers of the literature. Their literary output reveals information about the societies in which they produced and transmitted their work, about the knowledge that was held to be important in the training of ayurvedic *vaidyas*, and about the awareness within the community of authors who composed these texts concerning the social perceptions of disease and the stigmas associated with being ill. The illness narrative is a dynamic medium for communicating anxieties and observations, as well as for raising questions, about the conceptual and practical links between religion, social ethics, health, and healthcare. Information contained in these narratives, not to mention the unique role of narrative in the presentation of illness in classical India, has been understudied, if not completely overlooked, for decades in the historical study of Āyurveda. These stories offer physicians and patients a means to understand why sickness saddles a given body at a given time, as distinct from physiological causes of a particular disease and its symptoms. They therefore contribute powerfully to our understanding of Indian cultural history and especially the role of religion and society in the history of Indian medicine and, vice versa, the perceived applicability of religious ideas, ritual practices, and social relations in deliberations on health and illness.

At traditional gurukula clinics and modern ayurvedic hospitals in South India, I have seen explanatory models used differently by physicians and patients: for physicians, explanatory models tend to focus on disease, while for patients they typically address issues of illness. What is more, in contemporary ayurvedic colleges in India, just as in biomedical schools in America, medical students are encouraged to regard disease and biology as the physician's bailiwick and, for all intents and purposes, not to worry about the psychosocial and cultural aspects of the patient's experience of illness. Every doctor-patient interaction is different of course, and the sharing and eliciting of explanatory models between doctors and patients are often quite subtle. For example, doctors might not share the details of their explanatory models with their patients for fear of appearing too detached from what might be an otherwise traumatic discovery for their patients, or they might presume their patients would not understand the technical minutiae of their assessments. Conversely, patients might not readily divulge their rationale for seeking medical care in the first place, how their own perceptions of their sickness affect their social activity, and the degree to which they intend to follow the advice of their doctors. The contact and distance between explanatory models of doctors and patients can tell us a great deal about the level (or lack) of effectiveness in clinical communication. Attention to this has been growing over the past fifty years in biomedical schools in North America, where we are beginning to see the move toward a new medical humanism, or what

is now popularly referred to as "medical humanities" in biomedical school curricula.

In the Sanskrit literature of Āyurveda, narrative explanatory models (or illness narratives) both shape and reproduce social perceptions of illness through the portrayal of such things as religious conduct and interpersonal contact in explanations of why people become ill. They generally describe sequences of events that depict a person moving from a given condition of wellness to illness, and hence into the state of patienthood. The values and norms embedded in the stories read like rulings on socioreligious behaviors and attitudes; they also form a uniquely medical vision of the ideal person, typically understood to be a "healthy" (*svāsthya* or *ārogya*) person, and this person's opposite, namely, a patient (*rogin*, *ātura*, and *vyādhitā*). A patient's psychosocial experience of sickness in these stories is more often than not the result of a violation of social or ritual etiquette, a lapse in judgment, some kind of obvious social, legal, or religious impropriety (that is, *adharma*), or a combination of these faults. To an extent, most of the stories attend to the five categories of explanatory models offered by Kleinman. His five categories – [1] etiology, [2] onset and type(s) of symptoms, [3] pathology, [4] severity of sickness, and [5] treatment – provide a useful analytical guide for reading medical discourse in general, for they underscore both particular and capacious aspects of explanatory models in the medical context. The five areas query particular spheres of activity and influence in medical discourse, and thus gainfully lend themselves to precise analysis of specialized elements of medical practice. At the same time, collectively they also suggest a comprehensive and elastic enough canopy under the cover of which an explanatory model may be read to embrace all five areas, allowing for varying degrees of importance and expansion of each area into subareas or variations (such as, for example, a disease etiology determined according to humoral theory, seasonal cycle, or karmic analysis). Reading the medical narratives in the Sanskrit sources in view of Kleinman's five areas, it becomes clear these stories are meant to communicate the weightiness of social construction and religious practice. They reveal that classical Indian medical literati and practitioners were actively occupied, theoretically and in practice, with socioreligious developments in Indian cultural history, and they carefully constructed distinctively medical positions on such things as *karma* and rebirth and the implementation of Hindu *dharma* according to everyday variables like gender, class and caste, time of day, and season.⁷

That the events recounted in Āyurveda's narratives reappear throughout Hindu mythological literature suggests that these narratives carried a certain amount of cultural capital in premodern India and were (as they continue to be today) well known. Roland Barthes famously said that "myth hides nothing: its function is to distort, not to make disappear."⁸ The medical narratives of Āyurveda make use of mythic language and symbolism to bring slightly different meanings to traditional Hindu stories than they enjoyed elsewhere in Sanskrit literature. They neither wipe away the so-called religious import

nor gloss over the so-called medical situation. What they do, however, is play with, and draw associations between, what might appear like antinomies to the modern, biomedically oriented mind, especially the association between thought/knowledge and corporeal maladies.

The use of well-known religious stories to explain the experience of illness might affect the clinical encounter between doctors and patients by influencing professional and social perceptions of disease. For example, a narrative explanatory model for a wasting disease like "consumption" (*rājayakṣman*) based on the story of King Moon's rendezvous with the constellation Rohiṇī could have the effect of bridging a knowledge gap that might exist between a medical professional and a patient in a way that most other explanatory models of disease and somatic dysfunction could not. Standard accounts of consumption in the literature are intended for physicians and are based on highly specialized terminology and knowledge, such as medical theory (*tridoṣavidyā*), botany (*auśadhiśāstra*), clinical procedure (*prayoga*), and the like. A narrative model, in other words, uses information that in the premodern context would have been meaningful for both medical practitioners and patients, since patients would likely have known the story of King Moon but not the physiological theory undergirding wasting diseases like consumption. Reading these stories as part and parcel of the historical tradition of Āyurveda affords us a lens through which we might better understand how the compilers of the ayurvedic sources envisioned the good life, or more precisely "long life" – *āyus* – as the name Āyurveda ("knowledge for long life") represents and, on the basis of that vision, how they chose to portray health and sickness.

The form of narrative explanatory models in Āyurveda raises the crucial question of function and authorial motivation. Addressing this question nicely tests the aforementioned postulation of familiar cultural knowledge among doctors and patients: Does the use of knowledge familiar to patients in a discourse intended to explain and potentially affect bodily health bridge or further deepen the knowledge gap between patients and their physicians? To answer this question properly one would need to execute an inquiry into the production and intertwining of religio-ethical and somatic knowledge, who disseminates this knowledge, and ultimately who benefits from it. A fair treatment of these questions far exceeds the space provided here. That said, a cursory conjecture is worth offering, if for the primary reason that the intuitive response to these questions is likely to be that the use of popular myths to explain illness might bring the biophysiological knowledge of the physician and the patient's awareness of that knowledge closer together. Though that is indeed possible, I would venture to say that the use of narrative explanatory models in the Sanskrit medical sources could actually bolster the disparity of knowledge between medical practitioners and patients. The main reason for this has to do with the fact that many of the narratives in Sanskrit medical literature have several registers of meaning, and the discursive subtleties of social and moral judgment woven into the well-known stories are not typically evident on the stories' surfaces. The "meta-meanings" are often understood

only through intra- and intertextual references, which reveal these stories to be deeply rooted in religious ideology and quite heavy-handed in their expectations for, or denunciation of, certain social behaviors. Such messages are apt to elude patients who are ailing, perhaps desperately, and prone to a common assumption that when it comes to matters of health and sickness, physicians know best. If a patient is told or employs a narrative explanatory model to make sense of sickness, bodily dysfunction, or disease, that patient will internalize the norms and values couched in the story. If the story pervades the culture in which the patient has been brought up and lives, ideological strains are less likely to be obvious, and more likely to appear natural, beyond any particular agenda or interests other than returning health to an infirm body.

Case study: fever

To explore the role of religious discourse and the question of patient accountability for illness in the narrative explanatory models of ayurvedic literature, I now present an illness narrative about the origin of fever (*jvara*). The basic kernel, or mytheme, of the fever narrative occurs in the medical compendia (*saṃhitā*) of Caraka, Suśruta, Bhela, Vāgbhaṭa (*Aṣṭāṅgaḥṛdayasaṃhitā*), and Madhava. I take up only Caraka's version in the *Carakasamhitā*'s "Section on Therapeutics" (*Cikitsāsthāna*). This particular narrative is a recycled version of a popular Hindu myth commonly called "Dakṣa's Sacrifice," which can be found in a number of variations in Sanskrit literature.⁹ In the *Carakasamhitā* the narrative occurs in the form of a tutorial given by the celebrated medical sage, Ātreya Punarvasu, to his pupil, Agniveśa. The following is an abridged version of the story:

It has been said the condition of fever arises from attachment to possessions. Yet earlier, in the Section on Primary Causes, it was also said that fever arises from the intense anger of the god Rudra.

In the Second Cosmic Age, Rudra made a vow of non-anger for one thousand divine years (= 360,000 human years) ... Because the demons sustain themselves by obstructing people's religious observances, they hastened to block Rudra's vow. Though Dakṣa saw this, he disregarded it. Furthermore, when he was preparing his sacrifice, Dakṣa did not arrange the fixed share of offerings for Mahēśvara, even though the gods implored him to do so ...

At the conclusion of his vow, Rudra learned of Dakṣa's misconduct, and he became angry. He opened the eye on his forehead, and fire shot forth to burn the demons [who disturbed him during his vow]. Rudra then created a child to destroy Dakṣa's sacrifice. Ablaze with the fire of his father's anger, the child destroyed Dakṣa's sacrifice, and the crowd of gods and people in all directions were seized by an excruciating feeling of being in flames ...

The fearsome fire of Rudra's anger¹⁰ ... then asked his father, "What should I do for you now?" Rudra replied ... "You will become fever in the world at the start of life, at death, and among people who act improperly."¹¹

What explanatory function does the Dakṣa story perform? Sacrificial foibles of a legendary Hindu character, Dakṣa, from a popular myth at one and the same time reflect and cause fever, quickly conflating Dakṣa's ritual abilities and choices with the experiences of illness and wellbeing. Dakṣa embodies certain views about proper and improper disposition and ritual activity, while the storyline suggests the impact of behavior on the prevention of sickness. In view of Kleinman's classification of explanatory models, this illness narrative may be read as directly addressing areas one and two – etiology and the onset and type(s) of symptoms. Area five, treatment, is also implicated. In the remainder of this chapter, I explore the ways in which Caraka's fever narrative plies discourse about *dharma* and *karma* to explain the source, onset, and potential management of fever.

The etiological thrust of the narrative lies in the causal chain linking a person's decisions, actions, and wellbeing. The reference to attachment to possessions (*parigraha*, literally "grasping [for things]") in the opening verse is critical to make sense of this connection. The clue to its meaning is in the first section of the second verse, which says that Rudra took a vow of non-anger for 1000 divine years in the Second Age (the *Tretā Yuga*) of Hinduism's calendar of four cosmic ages.¹² On the surface, the relationship between these two verses is not readily apparent. Intratextual reference within the *Carakasamhitā* illuminates the significance of the cosmic ages to the *Carakasamhitā*'s overall estimation of human life. In the text's "Section on Measures" (*Vimānasthāna*), a passage on cosmological reckoning declares the following: the First Age (the *Kṛta* or *Satya Yuga*) was idyllic. When, in the Second Age, humans started to neglect their social, legal, and religious duties (*dharma*), bad things began to happen on Earth. The *Carakasamhitā*'s subsequent rationale for linking the descending cosmic ages with diminishing human health involves a parallel decrease in the universal observance of *dharma* among humankind alongside the inevitable decline from the First to the Fourth Cosmic Age, until a final dissolution occurs. During this cycle the text draws associations between the cosmos and the body. The text states that at the close of the First Age and at the start of the Second Age – when Rudra was in the midst of his vow of non-anger – *dharma* waned because of people's gluttonous behavior. Gluttony caused peoples' bodies to become heavy, which brought on fatigue and inattention. Human gluttony also led people to become attached to and to accumulate material things. Attachment to possessions and accumulation caused ownership, and ownership bred greed, which yielded deceit, violence, and desolation. Deprivations befell the natural world as well: a quarter less rainfall in each descending age fell, causing the earth's vitality to shrink by a fourth from age to age. This in turn caused an equal plummet in food

nutrition. People's diets suffered, the integrity of their bodies weakened, and sickness and disease quickly invaded human bodies.¹³ The lessening of *dharma* among humanity, alongside the descending ruinous cosmic ages, is central to the *Carakasamhitā*'s explanation about how human bodies open themselves up to fever (hence explanatory model area one, etiology). Capturing the simultaneous decline of *dharma* and escalation of sickness, the idea of being attached to possessions (*parigraha*) becomes a general cultural analogue for non-dharmic (*adharma*) qualities like greed, disrespect, and sacrificial negligence, for which the Dakṣa character neatly stands in as a metaphor. The *parigraha*-like behavior of Dakṣa effectively set the fall from grace in motion (hence explanatory model area two, onset of symptoms).

The compilers of the Dakṣa story in the *Carakasamhitā* structure our perception of fever by determining what evidence and issues are relevant to the medical condition. This narrative is of course neither exclusive to the *Carakasamhitā* nor *Āyurveda*, and the *Carakasamhitā*'s retelling of the story changes a few things from older and non-medical renditions of the story: it forefronts fever (especially in Rudra's final injunction to his "son") as something everyone experiences irrespective of birth, gender, and action. It also moves the sacrificial point of the myth away from more common accounts that include Dakṣa's dislike of his daughter Satī's husband, Śiva (Rudra), and Satī's subsequent self-immolation on her father's sacrificial fire, and uses the sacrificial carelessness fixed to the character of Dakṣa as a metaphor for physical woes that arise from not doing what one knows to be right according to Hindu *dharma*. The Sanskrit term *dakṣa* means "able" and "fit," suggesting that the character Dakṣa is betraying his own nature in some way through his actions. An explanatory model is, in Kleinman's words, "the main vehicle for the clinical construction of reality; [it] reveal[s] the cultural specificity and historicity of socially produced clinical reality, regardless of whether it is based upon scientific medical knowledge."¹⁴ Kleinman's remarks underscore the power of explanatory models to cultivate a vision of the world to be shared by patients and the people who treat them. The question we thus need to ask of *āyurvedic* texts that use storytelling to explain illness is not whether or not an illness narrative is "based upon scientific medical knowledge." As I argued earlier in this chapter, such investigative pursuits often produce analyses based on terminological assumptions about science and medicine that neither advance our understanding of *Āyurveda* nor uncover the breadth of interests in *Āyurveda*'s elucidation of long life. Our philological task here is not to question whether or not the Sanskrit medical classics address what we think medical science ought to address. Instead, it is to probe the functions of the compilers' narrative presentations of wellbeing and bodily functioning. How does the particular explanatory mode of the illness narrative shape and contribute to the compilers' overall discussions of health and illness? To ascertain the meanings of the classical texts, our cardinal philological pursuit, requires equal attention to *what* the texts present and *how* they present that material. Narrative tracts in *Āyurveda*'s classics like the *Carakasamhitā*'s

account of fever, structure our reception of the data they offer. These narratives cultivate a singularly ayurvedic sensibility in the reader, a special way of thinking about the body, that is attuned to the cultural mores and historical times in which they were produced. They also point to the centrality of Āyurveda to Indian cultural history and illustrate the extent to which the compilers of classical ayurvedic literature envisioned issues of social, ritual, legal, and moral decorum to impact bodily welfare and performance. To present this, a common trope for the illness narrative is to engage a cornerstone of Indian thought, the concept of dharma, which opens up the discussion of life to a larger commentary on how to live in the world.

By addressing this "how to" element, the illness narratives of Āyurveda also speak to the fifth area discussed by Kleinman, treatment, albeit indirectly. In the context of ayurvedic literature, we must include within Kleinman's area of treatment the subarea of prevention or preventative treatment, which typically lodges the moral of an illness narrative. It is the lesson to be gleaned after digesting the sequence of events that led a person to sickness and patienthood. For example, though it is not spelled out in the story itself, as spectators of Dakṣa's descent into patienthood we learn that not acting as Dakṣa acted is the best medicine. Dakṣa's story is an abject lesson. As he makes a series of bad choices, our understanding of the ethical attitudes of the story's compilers crystalizes, for we learn the types of behaviors they denounce as unwholesome. Illness is not discernable via dissection or systematic analysis of the body's humoral makeup, as it often is in a non-narrative explanatory model. It is perceived in the course of the lived life of the patient. As I have argued elsewhere, the compilers of these narratives assume the roles of ethicists, while the patients in their stories resemble ill-informed opponent-interlocutors like those the authors of Sanskrit philosophical literature frequently contrived.¹⁵ As the holder of erroneous "prior arguments" (*pūrvapakṣas*), which stand opposed to an author's own unimpeachable "subsequent arguments" (*uttarapakṣas*) and "established conclusions" (*siddhāntas*), the compilers of an illness narrative situate themselves as the Siddhāntins, the invariable winners of every argument; the patients are the Pūrvapakṣins, the invented debaters set up always to lose.

At the same time, Āyurveda's illness narratives are a good deal more than mock dialogues with opponent-interlocutors that suggest ineptitude and poor decisions are linked to wellbeing. In setting up the patient as an ill-informed individual, Āyurveda's illness narratives are suggestive of oral histories that convey social and religious conventions. Recounted as stories once told by famous medical sages like Ātreya Punarvasu and Kaśyapa, they are presented as "stories that were heard" (*śrutā kathā*) long ago or revealed "in the beginning" (*evāgre*) of time. Their timelessness and tradition-heavy pedigree, positioned outside of human history, lends gravity, if not a sense of infallibility, to the heuristic nature of the stories. Crucially, they place questions of healthcare at the center of the intersection of multiple cultural institutions. In the parlance of the modern university, categories like "science" and "religion" are

routinely invoked to make sense of the ways in which, or even why, a so-called medical system might entertain problems of moral and ethical consequence, rather than strictly adhere to empirical data of biology, pharmacology, and the like. Such classifications tend to disaggregate Āyurveda into parts that the tradition's compilers did not conceive as necessary. Articulations of health, illness, and disease occur in numerous modes in classical Āyurveda. Some appear medical, some appear religious and, often, some appear to overlap those two and other cultural domains. This suggests that categories long held to be opposed, such as science and religion, are inadequate or incompatible with the content we are trying to understand. Reading the Sanskrit medical classics through the lens of explanatory models can account for the multiple explicatory modes in Āyurveda without reducing them to non-ayurvedic categories.

Conclusion: a uniquely ayurvedic stance on duty and action (or, Moving beyond the categories of medicine and religion in Āyurveda's classical literature)

To conclude I would like to comment on Rudra's final directive to his offspring, the "angerfire" (*ikrodhāgni*) that erupted from his third eye. His injunction echoes a common trope in the Sanskrit illness narratives that at the end of the day all people fall under the general rubric of "patient," not simply because human bodies are susceptible to disease, which they naturally are, but because every person experiences the psychosocial experience of illness. Every person will at some time be a patient. What is more, since actions and decisions play a substantial role in health, every thinking and acting person is accountable for the illnesses she or he experiences. Stories like "Dakṣa's Sacrifice" help us to identify where a person might have gone wrong given the sickness that manifests.

After Dakṣa's sacrifice is destroyed, Rudra tells his angerfire to afflict human beings with fever at two fixed and inevitable stages of life – at birth and death – and in the event of a probable, though avertable, third instance: in cases of improper action. Let us look at improper acts first. Dakṣa acts improperly (*apacāra*) by not inviting Rudra to attend his sacrifice: his *dharma* as a sacrificer is to be hospitable to the gods. Because he does not welcome Rudra, Dakṣa exposes himself as well as those around him to the malady of fever. Of the three instances in which Rudra's angerfire manifests as fever, improper behavior is the most crucial for the compilers of the *Carakasamhitā*. This cause applies to everyday dharmic behavior that, more often than not, people can attend to and adjust in their lives. In the *Carakasamhitā*, fever is the fruit of *karma*, or one's actions. Action is explicitly tied to knowledge in this case. Indeed, in the *Carakasamhitā*, when one's *karma* produces illness, often the cause is a violation or misuse of knowledge (*prajñāparādha*).¹⁶ Violations of knowledge involve activities marked by poor judgment. In addition to his injudiciousness as a sacrificer, though he was aware of and

presumably able (*dakṣa*) to ward off the demons that pestered Rudra while he undertook his vow of non-anger, Dakṣa did nothing. Unlike other Sanskrit medical sources, such as the *Aṣṭāṅgahṛdayasaṃhitā* and the *Suśrutasaṃhitā*, which treat *karma* as the fuel driving rebirth and redeath, the *Carakasaṃhitā*, as Mitchell Weiss has noted, attempts to make *karma* clinically germane in the present moment.¹⁷ The story of “Dakṣa’s Sacrifice” is about a person’s karmic imprint today and the immediate repercussions of that imprint on one’s welfare. The fruits of one’s actions thus reveal one’s aptitude to have previously acted properly or improperly. Who determined the parameters of proper behavior? The *Carakasaṃhitā*’s compilers did. In this case and others in Caraka’s expansive text, as Surendranath Dasgupta documented, considerations of right and wrong, good and bad, and so forth, are informed by social-moral-legal teachings found in the Dharmaśāstra literature.¹⁸ To know if drawing on the wisdom of the Dharmaśāstras equates to the determination of moral values depends on certain sociological and ethnographic information to which we simply do not have access today. Of critical importance, for instance, is the extent to which the ayurvedic iteration of fever via “Dakṣa’s Sacrifice” has been engaged and internalized by physicians and patients in and since the classical era. That said, we know that the Sanskrit medical classics, of which the compendium of Caraka is the cornerstone, were manuals for training and practicing *vaidyas*. These texts were compiled for guiding clinical practice, in other words. It is not difficult to imagine how the positioning of *karma* and *dharma* as integral to the explanation of fever, and to the explanation of illness more generally, whether through the direct retellings of “Dakṣa’s Sacrifice” or indirectly by communicating the impact of social and ethical forces on bodily health and illness, could have influenced a *vaidya*’s clinical interaction with patients.

In the verse immediately following the fever narrative, the *Carakasaṃhitā* states that the occurrence of fever in one’s lifetime manifests in a human body as heat, aversion to food, thirst, lethargy, and heart pain. But at birth and death, it manifests in the form of *tamas*.¹⁹ Why *tamas*? The primary meaning of *tamas* is “darkness.” But here the term’s figurative meaning of ignorance – of “being in the dark” – is intended. To make sense of the way in which *tamas* is used in the *Carakasaṃhitā*’s fever narrative, embryological passages in a non-medical text, the *Mārkaṇḍeya Purāṇa*, are instructive.²⁰ The *Mārkaṇḍeya Purāṇa* depicts the fetus as fully aware of his or her previous births. Mindful of every deed and misdeed committed over countless lifetimes, a fetus knows what to do upon delivery from the womb to erase the “karmic residue” built up from multiple rebirths.²¹ The text goes on to explain that at the time a child exits the womb, the “illusion of Viṣṇu” (*vaiṣṇavīmāyā*) sweeps over the newborn and erases all memories, good and bad, of past lives.²² In the *Carakasaṃhitā*, fever has a function akin to Viṣṇu’s illusion in the *Mārkaṇḍeya Purāṇa*. Elsewhere in the *Carakasaṃhitā* there is a reference to the “wind of delivery” (*pruṣūtimāruta*); the text, however, does not elaborate on this “wind” to suggest that it has any effect on newborns at the moment of birth.²³ The

most incisive modern commentator on the impact of delivery on the memory of newborns in Sanskrit medical literature, Minoru Hara, has written about a phenomenon that erases the memory of previous lives at birth known as *janmaduḥkha*, the “suffering of birth.” It is the suffering of birth, Hara writes, from entering the bright, new, and cold world, covered in feces and amniotic fluid, from having been squeezed through a narrow passageway, “that is responsible for the loss of memory (*smṛti*) and knowledge (*vijñāna*), which the ordinary human being in the state of embryo is supposed to possess until the last moment of his stay in his mother’s womb.”²⁴ In the *Carakasaṃhitā*’s illness narrative of fever, a parallel story of traumatic life beginnings is suggested. The manifestation of *tamas* in the form of a fever at the moment of birth cloaks the newborn in a kind of anti-mnemonic darkness. This darkness effectively nullifies the newborn’s capacity to ensure that mistakes of past lives will not be repeated in the brand new life about to commence. Because fever also strikes all humans at the moment of death with the same *tamas* experienced at birth, it seems the *Carakasaṃhitā* neither leaves room for the soon-to-be-born child to remember things done in past lives nor to strategize about what to do in the next life to prevent the redoing of past misdeeds.

How might we make sense of the way in which the authors of the *Carakasaṃhitā* framed human life in *tamas*ic darkness? With fever at birth and death, they accentuate the empirical and practical significance of human actions, which proceed from one’s conceptions and views, in the here and now. The suggestion, then, is that biological wellbeing depends on more than a person’s immediate self-care, including regimens such as hygiene, diet, and exercise. The company one keeps and the awareness of one’s place and roles in society also matter. The story of fever in the *Carakasaṃhitā* demonstrates that personal wellbeing also depends on the extent to which people act according to their abilities and whether or not they perform their social, legal, and religious obligations.

Notes

- 1 Sontag (1978), passim: <http://www.nybooks.com/articles/archives/1978/jan/26/illness-as-metaphor/>.
- 2 Kleinman (1980), p. 105.
- 3 On the designations of narrative and non-narrative explication in the Sanskrit medical classics, see Cerulli (2012), pp. 4–8, passim.
- 4 Kleinman (1980), p. 107.
- 5 Chattopadhyaya (1986) is a classic example of this approach.
- 6 For a recent example of this tension, see the interview in Haag (2011) in which a *vaidya*-scholar of ayurvedic medicine simultaneously distances from Āyurveda the practice of storytelling as a valid means of explaining illness while also defending the narratives of the Sanskrit medical classics as symbolically rich, historically important, and instrumental to the tradition.
- 7 See, for example, the *Aṣṭāṅgahṛdayasaṃhitā*, Sūtrasthāna 2–3, in Kuṇṭe et al. (2002).
- 8 Barthes (1972), p. 121.
- 9 For a comprehensive study of “Dakṣa’s Sacrifice” in both non-medical and medical Sanskrit literature, see Cerulli (2012), pp. 50–9.

- 10 The formidable child created by the fire of Rudra's anger is called Vīrabhadra in some Purāṇic versions of "Dakṣa's Sacrifice," especially those that emphasize the death of Satī and the subsequent establishment of the *śāktapīṭhas*. However, neither the ayurvedic texts nor the *Carakasamhitā*'s eleventh-century commentator, Cakrapāṇidatta, refer to the child of Rudra's anger as Vīrabhadra.
- 11 Trikamji (1992). The abridged passage cited is taken from *Carakasamhitā*, Cikitsāsthāna 3, pp.14-25.
- 12 The four cosmic ages (*yugas*) are: [1] Satya or Kṛta, [2] Tretā, [3] Dvāpara, and [4] Kali.
- 13 *Carakasamhitā*, Vimānasthāna 3, pp. 24-7.
- 14 Kleinman (1980), p. 110.
- 15 Cerulli (2012), pp. 158-9.
- 16 Weiss (1980), pp. 110-15.
- 17 Weiss (1980), p. 110.
- 18 Dasgupta (1968), pp. 405ff. offers a succinct and clear study of ethics and dharma in the *Carakasamhitā*. See also Wujastyk (2004).
- 19 *Carakasamhitā*, Cikitsāsthāna 3, p. 26.
- 20 Although the embryological passages in the *Mārkaṇḍeya Purāṇa* (Singh and Goswami [1984-6] postdate the *Carakasamhitā*, *Mārkaṇḍeya*'s use of the concept *tamas* in reference to experiences at the beginning of life are strikingly similar to the *Carakasamhitā*'s use of the term. These passages are therefore helpful in analyzing the medical literature. And while it is possible that the compilers of the *Mārkaṇḍeya Purāṇa* borrowed and elaborated the association of *tamas* with birth from the *Carakasamhitā*, this is not a question that I can pursue or broach here.
- 21 *Mārkaṇḍeya Purāṇa* 10, pp. 1-7, 48-95; 11, pp. 1-32.
- 22 E.g. *Mārkaṇḍeya Purāṇa* 11, p. 19.
- 23 *Carakasamhitā*, Śātrasthāna 6, p. 24.
- 24 Hara (1980), p. 149.

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