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Ayurvedic Interiors: Person, Space, and Episteme in Three Medical Practices

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Modernizing Ayurveda

Ayurveda is the name given to a complex of South Asian healing practices that have been traced back as far as 600 B.C. Ethnographers argue that the phenomenology of health in Ayurveda, particularly its formulations of person and illness, are culturally distinct from those of biomedicine (also referred to as modern medicine or allopathy). They note that psychic and somatic components of health, which are isolated from one another in the biomedical paradigm, are integrated in the Ayurvedic paradigm. Ethnographers also observe that while biomedicine conceives the body and person as solid and bounded, Ayurveda conceives the body and person as fluid and penetrable, engaged in a continuous interchange with the social and natural environment (Kakar 1982; Zimmermann 1987). Thus, Ayurveda frequently frames illness as socio-psychosomatic distress and understands patients as part of an enclosing social, climatic, or cosmic field (Nichter 1981; von Schmadel and Hochkirchen 1987). Moreover, many ethnographers demonstrate that while biomedicine configures illness as a discrete entity, Ayurveda configures illness as a disruption in delicate somatic, climatic, and social systems of balance (Kakar 1982; Trawick 1991; Zimmermann 1987). If biomedicine generally understands body, person, and illness as objects, Ayurveda generally understands body, person, and illness as processes and patterns of relationships.

Research focused on the historical praxis of contemporary Ayurveda addresses the adaptations of Ayurveda to the complex medical field of 20th-century South Asia. In the early 19th century, the structure of Ayurvedic training was a guru-disciple apprenticeship located in nonhospital settings. Political and historical studies document the standardization of Ayurveda through the introduction, early in this century, of institutions such as medical colleges, profes-

sional associations, and hospitals, which have increasingly replaced apprentice-
ship and practice in noninstitutional settings (Brass 1972; Leslie 1976). These
historical accounts are complemented by ethnographic accounts that have ex-
amined how Ayurveda interacts with other healing ideologies in local contexts
of medical pluralism (Nichter and Nordstrom 1989; Nordstrom 1988). These
ethnographies explore the ways in which Ayurvedic patients and practitioners
strike a balance between accepting elements of competing medical systems and
maintaining the distinctiveness of Ayurvedic insights and methods. It is argued
that biomedical beliefs, practices, and substances are absorbed into contempo-
rary Ayurvedic practice without necessarily disturbing its underlying para-
digms of person and illness (Nichter and Nordstrom 1989; Nordstrom 1989; Ta-

Yet historians and critical theorists of biomedicine suggest that medical in-
institutions play an important role in the construction of core medical categories.
Foucault (1973) in particular argues that the anatomo-clinical method of the
modern teaching hospital locates disease in the interior of the body. Dissection
allows the doctor to trace the path of disease through an internal corporeal space.
The perception of disease as localized at various somatic sites shifts attention
from readily observable manifestations of disease to signs that are solicited
from the interior of the body by instruments such as stethoscopes. Symptoms
playing on the surface are no longer considered simply facets of the illness or
even the primary and exhaustive signifiers of it. The temporal suffering of the
patient becomes epiphenomenal; it is the spatially described organic dysfunc-
tion that is now the object of medicine. Diseases, moreover, are no longer
nosological categories spread across a natural historical landscape; instead they
are entities enclosed in an individual body.

Following Foucault, medical sociologists claim that the technologies and
organization of the modern hospital allow disease to be separated from the
larger context of the social environment and to be discovered in bodies, which
are construed as passive. They suggest that modern clinical methods continually
reinforce the formulation of the body and person as isolated, solid, and acted
upon rather than as acting (Armstrong 1987; Sullivan 1986). Some medical so-
ciologists argue that even the holistic health paradigms of the last two decades,
which include psychological, social, and physiological systemic factors in the
description of disease, are fashioned by modern medical structures into new
means of patient reification and control (Arney and Bergen 1984). Such studies
implicitly challenge the view that modern medical institutions can be introduced
into Ayurvedic medicine without altering its underlying formulations of person
and illness. They raise the question of whether and in what ways modern teach-
ing hospitals and clinics and their attendant methodologies are reworking Ayur-
vedic phenomenology.

The application of Foucaultian theory outside of Europe and North Amer-
ica has led to an expanded analysis of modern discourses.3 In his study of the
colonization of Egypt, for example, Mitchell (1988) points out that modern
modes of knowledge not only construct persons through an opposition between
interior and exterior but also construct the social body and knowledge itself through such an opposition. He demonstrates how a modern epistemology establishes a binary split between reality and its representations, interior and exterior, private and public. This epistemology is evident, for example, in an urban architecture of facades that represent their interiors to an onlooker who is situated outside of the spaces to be perceived. Mitchell discusses how this spatial split between facade and interior, form and content, architectural sign and institutional referent was missing from precolonial Egyptian towns. The architectural conceptions introduced by the colonialists are one indication of an epistemological project that involves the scientific cataloging of reality and the exhibitionary display of the world. Mitchell further describes how this epistemological project, which he terms enframing, may be obviated by alternative orderings of space that do not obey the binarism of reality and representation, interior and exterior, public and private. Mitchell (1988) traces the binarism of the modern episteme through transformations of several Egyptian institutions during the colonial period. In each case he notes how enframing came into conflict with precolonial epistemologies.

While Mitchell’s (1988) account focuses on a process of colonization, it documents an epistemological collision that may still occur in postcolonial cross-cultural encounters. Recently, I visited several Ayurvedic physicians and institutions in India in order to begin to investigate the influence of modern medical institutions on Ayurvedic conceptions. In this article, I report on a series of ethnographic moments with each of three private practitioners.4 The first, Vaidya (abbr., Vd.) Sharma, in his eighties, was trained largely in the context of a guru-disciple relationship, although he also interned briefly with a biomedical doctor. The second, Dr. Karnik, in his sixties, was trained and worked for many years in modern-style Ayurvedic teaching hospitals. The third, Dr. Shukla, in his forties, is the son of an Ayurvedic physician of Vd. Sharma’s generation; like Dr. Karnik, however, he was trained in modern-style teaching hospitals. All three of these practitioners are residents of an urban metropolis. All three have been involved in Ayurvedic professional associations to one degree or another. Dr. Karnik and Dr. Shukla have also been involved in Ayurvedic research. While all three practitioners treat patients from a range of socioeconomic backgrounds, Vd. Sharma’s patients are generally less educated than those of Dr. Karnik and Dr. Shukla.

I went to India assuming my detachment from the modern modes of knowledge whose infiltration I wanted to document. Yet my own modern assumptions were reflected back at me in two ways: first, through answers to my questions that resisted the epistemological thrust of those questions, and second, through my confusion about the public nature of clinical space. One assumption was that medical phenomena can be mapped onto the space of the person; another assumption was that local medical practices can be isolated and defined; and a third assumption was that illness is an essentially private matter. In my observation of Ayurvedic practice, these three aspects of the interiority (the enframability, in Mitchell’s terms) of illness and medicine eluded me, flirted with me, and
made quixotic flash appearances, but ultimately opened out into spaces that I cannot easily categorize as either interior or exterior.

Vd. Sharma, Dr. Karnik, and Dr. Shukla are all in their own ways concerned with the fate of Ayurveda. In both their discourse and their practice they participate in a dialogue not only with their anthropological interlocutor but also with a larger field of voices and forces. Twentieth-century Ayurveda is practiced not simply inside or outside modern medical institutions but within a political context that reflects the ideological conflicts of recent Indian history. The first Ayurvedic college in modern times was established in the early 1800s as part of an orientalist interest in ancient Indian knowledge. During this period the study of Vedic texts extended to the most ancient Ayurvedic texts, particularly the Caraka Samhita, the Susruta Samhita, and the Ashtanga Samagraha. It is possible that some of the importance of these three texts in contemporary Ayurvedic education stems from the orientalist valorization of classical Sanskrit texts. In any case, the early allies of Ayurveda quickly lost their influence in British policy. In 1835, the first Ayurvedic hospital was quickly closed with a decree that only Western medicine could receive state sponsorship and support. The loss of British support at this stage was all the more critical since both British and Mogul rule had been gradually eroding the Indian royalty on which Ayurvedic practitioners had previously relied for support.

It was not until the early 20th century that Ayurvedic hospitals and colleges began to develop again through the initiatives of Ayurvedic doctors and some of the Indian provinces. These institutions were modeled after the biomedical institutions established over the previous century. By this time biomedicine had a vast hold on the Indian subcontinent. Ayurvedic doctors managed to promote Ayurveda partly on a nationalist platform by arguing its unique connection to Indian cultural identity. In riding the wave of Indian nationalism, 20th-century Ayurveda was caught in a central paradox of the nationalist project, the promotion of a distinctive cultural identity through the introduction of institutions modeled on an international norm (Anderson 1991). Throughout most of this century, Ayurvedic practitioners have been split between those who advocate a śuddha (pure) Ayurveda and those who advocate an Ayurveda that is integrated with allopathy. So-called śuddha Ayurveda, however, must be understood largely as an ideological construct. Even Ayurveda that is not deliberately mixed with biomedicine is inevitably marked by the complex philosophical and practical encounter with biomedicine over the last two centuries. The debate between advocates of “pure” and “syncretic” Ayurveda continues despite legislation passed in the early 1970s that established national governmental support and sponsorship of a separate (nonintegrated) system of Ayurvedic education. Yet the two camps have been united in their identification of Ayurveda as an important symbol of national identity and their support for the introduction of modern institutions and methodologies to varying degrees (Brass 1972; Leslie 1976). They are also generally united in an acknowledgment that Ayurveda is drastically underfunded in comparison to biomedicine.
Ayurveda, then, exists in constant economic and ideological competition with biomedicine. The introduction of modern medical institutions into Ayurveda is accompanied by a medical discourse that unfolds in continual dialogue with allopathy. Science is a term that assumes extraordinary significance in this dialogue. Prominent Ayurvedic doctors have struggled for decades to defend Ayurveda as a science. The word science is adopted by Ayurvedic doctors (as by many other kinds of doctors) as a sign for a universal knowledge that transcends national and cultural boundaries. For most Ayurvedic doctors today the question seems to be not whether Ayurveda is a science (indeed, the root veda is routinely translated as science) but rather how it might differ from other sciences.

Increasingly, interpretations of Ayurveda are shaped not only by a political contest with allopathy but by such transnational health care trends as the interest in holistic medicine (Leslie 1992; Zimmermann 1992). Ayurvedic critiques of biomedicine over the last few decades resemble the critiques of alternative health movements in Europe and North America. The authors of the Ayurvedic critiques argue that allopathy treats only the disease while Ayurveda treats the whole patient. They observe that biomedicine is based on a mind-body dichotomy and that Ayurvedic treatment is predicated on mind-body interdependence. While alternative health proponents suggest that doctors should extend their attention beyond pathology to the social and environmental factors of disease, contemporary Ayurvedic proponents note that Ayurvedic doctors have considered such factors for centuries. It is not surprising, therefore, that contemporary definitions of Ayurveda draw not only on orientalist and biomedical discourses but on alternative health discourses as well.

In this article, I focus on three practitioners’ points of engagement with particular projects of enframing. It should not be inferred that their interpretations of Ayurveda are collapsible into an encounter with modernity. Nonetheless their interpretations are certainly shaped by an encounter with modernity that takes place on various fronts, from the purely medical to the socio-moral. I will argue that each of these physicians resists modern modes of knowledge at different levels, Vd. Sharma at the level of medicine itself, Dr. Karnik at the level of social science, and Dr. Shukla at the level of neo-orientalist commodification. My original research intent was to study the ways in which the corpus of Ayurvedic knowledge had been changed by or preserved from modern disciplinary modes of knowledge. My proposed methodology was a comparison of the practices of physicians ranging from older-generation vaidyas (Ayurvedic practitioners) who had been trained by their gurus to vaidyas who had been trained in modern university settings. My interviews and observations were designed to collect data about diagnosis and treatment procedures that would reveal the underlying models of body and illness being used by each group of practitioners. In this way, I expected to be able to trace the effect of modern institutional procedures on Ayurvedic phenomenology. In a sense, my research was intended to diagnose the extent to which the disease of modernity had invaded the corpus of Ayurvedic knowledge. The biomedical metaphor here is useful because it reveals that
such a methodology is itself deeply embedded in a modern epistemological framework. What follows is an account of three practitioners’ strategic constructions of Ayurvedic knowledge within a politically charged field of actors that includes biomedical doctors, government agencies, ambivalent patients, social researchers, and non-Indian consumers of Indian “culture.” The purpose of this article is to suggest that Ayurvedic knowledge may be reformulated not only through institutional practices but through the discursive maneuvers of Ayurvedic doctors who seek to evade the tidy (en) closures of modern epistemological frames.

Going Deep

Dressed in a white dhoti and carrying a black umbrella, Vaidya Sharma leads me through a maze of streets toward what he refers to as his dispensary. On the way we kick off our sandals at a Hindu temple to do puja (loosely translatable as ritual prayer) at a murti (sacred image) of Vishnu and Lakshmi. The temple consists of a roof supported by pillars and a marble floor raised off the street by two or three stone steps. There are no walls or doors. The threshold is marked by the disorderly rows of muddy shoes left by the temple-goers. I stand in a queue of muttering men facing the murti, while off to one side a circle of women is seated, chanting. I marvel at how the others can do anything resembling prayer in such a noisy, chaotic, and unenclosed place, open to the surrounding marketplace. From the temple we pass through a narrow lane lined with stalls selling brass incense holders, murtis, gaudy silk cloths fringed with gold tinsel, and other items used in worship. Vd. Sharma tells me that this is the dirtiest and most crowded part of the city. We pass into a narrow street barred from taxis or bullock carts by the sheer press of pedestrians. From there we turn into a dirt alley.

Vd. Sharma’s dispensary is a space virtually without a facade, in Mitchell’s (1988) terms. One approaches it through narrow twisting passages that offer no vantage point from which the dispensary or its building can be viewed. The rickety stairs leading to the dispensary begin in a corner of the alley that is the workshop of a metal polisher, who is hard at work shining silver chains. Above one of the doors opening off the dark hallway at the top of the stairs is a Hindi sign displaying Vd. Sharma’s name. He unlocks a padlock and leads me into a tiny entryway. From there he guides me into the dispensary, which consists of one large room with a window at the end opening onto a balcony overlooking the street. Vd. Sharma installs himself in a chair at the end of the room. The chair is wedged between a counter where he and his assistants mix up medicines and a small table where he makes notes. Patients sit at this same table, catty-corner from Vd. Sharma, detailing their complaints above the sounds of street vendors and honking horns. On the other side of the desk is an examination couch which was never used as such during any of my visits. The outer portion of the room is lined with cupboards crammed with bags and bottles of medicinal substances. A dusty fan suspended from the ceiling whirls slowly. There is a wooden bench along one wall where patients await their turn. The consultation area can be
separated from the waiting area by a sliding partition; it is always left open, however. Since there is no air conditioning the outer doors are always ajar as well. Occasionally children from neighboring homes wander in to watch or interact with the doctor, his assistants, or his assistants’ children.

If, in Vd. Sharma’s practice, the categories of public and private continuously overlap in the ordering of space, the categories of interior and exterior overlap in the orderings of health and illness. In answer to my first question about diagnosis, Vd. Sharma emphasizes the importance of “going deep with the patient.” “Going deep” does not imply penetration to the malfunctioning organ but penetration to a network of forces unknown to modern anatomy. Vd. Sharma provides an impromptu translation of a passage in an Ayurvedic text as follows: “Only the vaidya physician who goes to the deep and root of the soul and mana [usually translated as mind but also including much of the connotation of the English heart in its nonanatomical sense] of the patient is the real vaidya.” The purpose of going deep is to find out “which dosas are there, which dhatus are affected, which organ is affected, and what is the prakrti of the patient.”

Of these four factors affecting the illness, only two, the dhatus (which is usually translated as tissue, though the inadequacy of the translation can be seen in the fact that one of the dhatus is semen) and the organ, can be thought of as contained within the body. Prakrti is usually translated as constitution. The patient’s prakrti can be defined as the balance of dosas expressed in his or her body type and behavior, affinities, and aversions. According to Vd. Sharma, a person’s prakrti can change slowly due to the influences of medicine, food, and climate. Prakrti, therefore, is less a characteristic of the patient than a relationship between the patient and her environment. The word dosas is usually translated as humors, while the three dosas, vata, pitta, and kapha, are usually translated as wind, bile, and phlegm, respectively. These translations are misleading, however, in their identification of dosas with substances inside the body. More accurately, the dosas are principles that are linked through an elaborate system of correspondences not only to somatic processes but to processes in the natural environment (Zimmermann 1987). Zimmermann has written that Ayurvedic knowledge rests on an “analogy between the living body (microcosm) and the surrounding world (macrocosm)” (1987:119). Yet the dichotomy between microcosm and macrocosm and the analogy that bridges that dichotomy may be requirements of a modern mode of thought. In many versions of Ayurvedic phenomenology, body, society, and world seem rather to be folded into one another in convoluted ways. Vata, pitta, and kapha, for example, correspond also to types of behavior and to the astrological elements of air, fire, and water/earth. Thus the balance of the dosas is manifest not only in physical phenomena such as pulse movement or skin color but also in habits such as athleticism or lethargy and in the positions of the planets at the time of the patient’s birth.

Vd. Sharma’s diagnosis consists primarily of darśan and of talking to the patient. Darśan literally means seeing but in many contexts also carries the connotation of imbibing another’s presence. For Vd. Sharma, darśan includes an examination of the tongue, eyes, skin color, and so on. He says, “Darśan—look at
a patient and you come to conclusions. . . . We see the tongue, eyes, yellowish, bright or not . . . dry or not, burning or not.” It is only when he reaches across the tiny table to take the patient’s pulse that Vd. Sharma seems to try to solicit signs from the patient’s interior. Yet pulse diagnosis is used not so much to assess the state of the circulatory system as to determine prakrti. The qualities of the pulse vary according to the predominant dośa. In the oldest texts discussing pulse diagnosis the vata pulse is compared to the movement of a leech or snake, the pitta pulse to the movements of a frog, and the kapha pulse to the movements of a goose or a swan. When Vd. Sharma practices darśan he does not seem to be reading signs that refer to the hidden essence of the patient’s illness. Rather, he seems to be observing the visible aspects of the patient’s illness in order to construct a narrative that includes the less visible aspects. Pulse motion and tongue color are not so much symptoms of a disease entity as glimpses of a disease process unfolding between patient and world.

Vd. Sharma is not averse to using modern diagnostic technology, particularly to measure the efficacy of his treatments. He cautions, however, that modern diagnostic tools will not always give an accurate account of a patient’s state of health. He compares two patients, one with a good hemoglobin count who is always exhausted and the other with a low hemoglobin count who “does his good work.” Vd. Sharma tells me that in the second case, the patient’s “general vitality and the strength in the blood cells, hear me, is so good that he can digest . . . and do his life’s work. . . . So here the comparison [between Ayurvedic and modern diagnosis] won’t help us.” Moreover, Vd. Sharma says that he “will accept what the patient says” over the results of modern tests. In Vd. Sharma’s practice Foucault’s interior gaze is used for corroborative purposes only. Although Vd. Sharma does ask the patient about his complaints he tends to emphasize darśan more than interrogation.

Vd. Sharma’s treatment, like his diagnostic method, goes deep into the patient’s life, but not necessarily deep into his or her body. He recites to me the prescriptions for health in the oldest Ayurvedic texts. According to these prescriptions, he tells me, one should rise before sunrise and perform breathing and other yogic exercises and prayer. He correlates this prescription with the English aphorism “Early to bed, early to rise,” although this aphorism, of course, does not include yoga, which is arguably as much a form of meditation as a form of exercise, let alone prayer. “Preventive medicine,” according to Vd. Sharma, involves three considerations: hygiene, seasons and environs, and diet. Health is broadly defined as a state in which the dośas are balanced, the dhatus are in “required form, energy,” the digestive system and mala kriya, “the whole eliminative function,” are in order, and the mind is happy. He quotes and translates an Ayurvedic aphorism: “Who is very satisfied, easily at enjoyment and peace, in aatma [soul or self, but not in the sense of personality], man [mind/heart], and indriya [organs] . . . full of joy, he is the only healthy man.” He continues, “Then again I come to my, this religious philosophy, Ayurvedic philosophy, or philosophy. If one doesn’t control the attachment of food, the attachment of taste—
so I advise you not to take chilis, but you are fond of chilis, suppose, and you take against my advice, and you are going to meet suffering."

Vd. Sharma’s general philosophy manifests in very specific advice for particular patients. “In Ayurveda what they say, ‘Who is the best vaidya?’ [The one] who can counsel the patient,” Vd. Sharma informs me. His own counseling most often takes the form of advice about diet, as in the above example. Yet diet is not only a matter of likes and dislikes, but of social and religious affiliations. He tells me the story of one patient with “hot yellow” urine, “red inflammation in legs,” and only “four grams hemoglobin.” He prescribed four to eight ounces of honey per day with one lime, and water in which dried grapes had been soaked. The patient stayed on this diet for two months. In addition he was treated with various Ayurvedic medications. After a year and a half of treatment, the hemoglobin count rose to eight or nine. Then, because the patient was a Parsi (and therefore, a meat eater), Vd. Sharma told him, “If you want to get better earlier take fresh liver of goat, bring it, crush it, put one or two liters of water, drink one-quarter of it, prepare it nicely, and then drink with lime and sugar.” He concludes, “So I am not against even all these things.” In other words, despite his own vegetarianism he is willing to prescribe meat where appropriate to the social situation of the patient.

Considerations of treatment also extend beyond the patient’s social world to the climate. A patient with a lung problem is told to continue his course of antibiotics but also to take tulsi (basil) brewed in boiling water as a nerve stimulant and general tonic. Vd. Sharma explains that because the patient lives in a moist climate, antibiotics are appropriate. In a drier climate antibiotics would not be necessary. In Vd. Sharma’s practice, antibiotics have been swallowed into a classificatory schema of substances, both somatic and environmental, whose properties interact for the production of various deleterious, indifferent, or curative effects. Antibiotics are understood, like all medications, not only according to their specific effect but according to more general properties that participate in a vast organization of rasa, translated as taste, savor, or juice, and guna, translated as quality. Zimmermann points out, however, that the rasa are not merely “flavors” accessible to the senses but “essences” circulating in the landscape (Zimmermann 1987:9). Treatment, therefore, is very much a matter of orchestrating or directing a flow of savors and qualities through the cosmic and somatic terrains. Vd. Sharma performs this orchestration from his small counter by reaching over his head for various glass jars filled with brown, ocher, orange, and red powders.

It is apt that Vd. Sharma refers to his private practice as a dispensary since a great deal of his time is spent preparing medicines. Each medicine prescribed is mixed while the patient waits. Vd. Sharma carefully removes some powder from a jar on a flat knife which serves as an instrument of approximate measure. He then taps the powder off the knife into a small pile on a page torn out of a magazine. He lines up a specific number of such piles for each herb or mineral according to the measurement specified in the recipe scribbled on a piece of paper at his elbow. Then he pours the contents of this paper into a mortar.
he or one of his assistants pounds and mixes it, and finally pours out small amounts of the finished compound onto two-inch-square pieces of brown paper which are then folded into neat envelopes. Each of these packets is one dose. I ask if he repeats mantras as he mixes the medicine (as is recommended in some of the Ayurvedic texts). He says no, that he must concentrate on mixing the medicine accurately. But later he says, “If you go on concentrating on God that does help here . . . spontaneously.” He says also that each vaidya is different, “like two bakers preparing bread.” Even though the ingredients are the same, the “judgment, efficiency, experience, and knowledge” of the person preparing the medicine has a large effect. Certainly Vd. Sharma’s units of powder balanced on the flat surface of the knife do not conform to a strict standard of measurement. When I complain of a sore throat, Vd. Sharma gives me a powder that tastes strongly of cardamom. Later another doctor gives me what I am told is the same medicine, but the cardamom flavor is missing. I ask Vd. Sharma’s opinion of the prepackaged Ayurvedic drugs now on the market. He replies, “I am not so much in favor but there is no alternative. . . . We have to accept realities here.” For Vd. Sharma the ideal of standardization holds no particular glamour. A method of mixing medicines that a modern pharmacist would be constrained to call inaccurate is for Vd. Sharma an act of carefulness born of devotion, exactitude born of concentration. The subjectivity implied, to a modern mind, by a practice whereby every vaidya brews a different potion is simply not an issue here. Nor is the seeming objectivity of the practice whereby Ayurvedic products are mass-produced according to scientifically repeated (and, more importantly, repeatable) formulae.

Vd. Sharma neatly falls into a category that some Ayurvedic practitioners working within modern institutional settings call “the traditional practitioner.” Not having been trained in the anatomo-clinical method, he seems to work with a model of the person that is rather different from that described in an anatomical text. At the end of our loosely structured interview, I have planned to request that he draw me a picture of the person as conceptualized by Ayurveda. Before I even attempt this question, however, I have developed a deep perplexity about how I am going to get it across. I am far from certain that I can explain what I mean by person, with all of its social science nuances.11 Sidestepping this abstraction I plunge ahead. I ask Vd. Sharma if he can diagram for me the relationships among the dosas, dhatus, and organs. He waves his hand dismissively and says, “In Jamnagar they have some maps of all this. . . . I belong to the old school of thought.” He refers me to another Ayurvedic doctor, a “modernist” who can explain how these things are “interpreted in the modern technology.” I persist: “You don’t think of these relationships in a visual way?” “I think, but in my way,” he replies. “I cannot satisfy you in that.” I try shifting my terms, saying, “I’m not looking for anything in particular. I’m just curious about how, whether or not, you know, the way the body, the way Ayurveda looks at the body could be diagrammed.” Vd. Sharma responds, “Now suppose you are here for three months. My way is to prove you the results. . . . Because instead of reading very deeply I experienced and experimented nicely in my life and found results.” Vd.
Sharma will not (or perhaps cannot) sketch the dosas or dhatus, but he will track them over a period of months along a particular course of treatment.

Zimmermann (1987) contrasts the motivated knowledge of the earliest Ayurvedic texts with the classificatory knowledge of modern science. He argues that a knowledge of chemical substance or physical function that is inextricably integrated with strategies of life and health is “anthropocentric.” He writes, “The listing and description of living beings do not constitute an end in themselves but are subordinated to a normative aim of some kind, whether it be ritual or political, astrological or medical” (Zimmermann 1987:130). For the early Ayurvedists, he asserts, the taxonomies of a true zoology or physiology are unthinkable. “Instead, based on a Sanskrit image, there are endless ‘garlands of names’ (namamala). Onto these name lists are grafted an amazing combinative system of ‘savors’ (rasa) and ‘qualities’ (guna)” (Zimmermann 1987:96). Ayurvedic phenomenology is logico-poetic and mythical, organized according to metrical principles and fantastic categories (Zimmermann 1987:103, 133). The question is whether the modern ordering of phenomena, which claims to be autonomous from the situation of the knower, deserves to be privileged over an ordering of phenomena that is precisely oriented by the situation of the knower. Many contemporary theorists would argue that a knowledge that asserts its own positivity is merely constructing a dichotomy between the observer and the object-world. Inden, for example, writes that “the representational theory of knowledge . . . claims in its braver moments” that “taxonomic or typological knowledge . . . simply mirrors what exists out there” (1990:33). In contrast, Inden insists that “the knowledge of the knower is not a disinterested mental representation of an external, natural reality. It is a construct that is always situated in a world apprehended through specific knowledges and motivated by practices in it” (1990:33). Medical knowledge has the problematic position of straddling the social and the natural. Yet finally what medicine is perhaps capable of teaching is that the social and the natural are not so clearly distinguishable. For Vd. Sharma, dosas and dhatus have meaning not within a phenomenological museum but within a particular trajectory of healing. The next time I ask if dosas and dhatus can be diagrammed, my respondent replies, “Very difficult.” The gist of his answer is in close parallel to Vd. Sharma’s: dosas and dhatus have to be observed; they are processes happening over time, not objects in space.

Having not yet visited the Ayurvedic college at Jamnagar, which is considered to have a curriculum less influenced by biomedicine than some of the other Ayurvedic colleges, I am not sure whether the diagrams Vd. Sharma refers to are anatomical diagrams or diagrams that portray the relationships among dosas and dhatus. Either way it is clear that he views the diagrams I am asking for as producible through the language of “modern technology.” Every Ayurvedic anatomy department that I visited displayed countless anatomical sculptures with organs duly exposed and labeled in Sanskrit as well as shelf after shelf of jars containing pickled brains, hearts, and malformed fetuses. In the dissection rooms small groups of students stood over cadavers separating the muscles of the foot, for example, with precision tools. Yet I did not see a single diagram of
the doṣas which are so central to Ayurvedic diagnosis and treatment. Zimmermann comments that in classical Ayurveda, there can be no map or topography of the body but only an “economy” of the body, an account of a flow of qualities that exaggerate or deplete one another (1979:7, cited in Kakar 1982:234).

When Daniel (1984) asked his informants to draw a picture of the Tamil ār and the Tamil kirāmam, either one of which might be translated as village, he received two very different sets of drawings. The kirāmam had fixed, standardized, state-determined boundaries which were exactly known only by surveyors and government officials. The ār had more elastic boundaries, marked by sacred landmarks and capable of various interpretations by the members of the ār (Daniel 1984). The kirāmam is analogous to the anatomical diagram in which the shape and position of the organs is fixed, standardized, and determined by the canons of scientific positivism. The hypothetical diagram of the doṣas and dhatus would be analogous to the ār. My consultants, however, are reluctant to conceptualize these in spatial terms.

These Ayurvedic phenomena also escape another type of description. Vd. Sharma shows me the notes he keeps on particular patients. There are long lists of physical and emotional complaints interspersed with biomedical disease terms. Nowhere, however, do I see a record of prakṛti, or of the particular disequilibrium of the doṣas. When I ask Vd. Sharma about this omission he replies in much the same way he replied to my request for a diagram. He tells me, “I am a simple practitioner, not working in institute or hospital, so I’m not expected to write down all these things. They are in my mind.” It is true that prakṛti is recorded in hospital charts; in the wards I visited, however, it seemed to be relegated to the bottom and seldom-consulted page of a clipboard containing a thick sheaf of papers. The records of patients in both private clinics and hospitals do contain detailed reports of physical complaints, biomedically defined conditions, test results, and drugs or therapies administered. There are at least two possible interpretations of the relative absence of attention to doṣa or prakṛti in the written record. On the one hand, the concept of prakṛti may be considered less crucial than the other items recorded. While this is conceivable in some of the modern-style Ayurvedic hospitals, it is clearly not the case in Vd. Sharma’s dispensary. He reiterated more than once the importance of prakṛti to diagnosis and treatment. A more plausible interpretation is that the concept of prakṛti is not easily framed within the modern instrument of the medical chart. Vd. Sharma informs me that in the past a vaidya would have kept all of his knowledge of a patient in his mind. Other practitioners deny this; the crucial point is that, in Vd. Sharma’s view, the medical record is a modern device appropriate to modern categories of information. If prakṛti refuses to be contained within the patient, constantly referring the observer to a flow of energies between patient and environment, perhaps it also refuses to be contained within a standardized record of illness. In Vd. Sharma’s practice, at least, it seems to require narration rather than listing, measurement, and classification. The relative omission of prakṛti from medical records has the curious effect of both privileging and erasure. By its exclusion, it is marked simultaneously as information that eludes
scientific methods of data collection and as information that is peripheral, even
diaphanous. Yet for Vd. Sharma the key fact is that the knowledge of prakṛti is
“in his mind.” The dosas that evade Foucaultian surveillance, including the sur-
veillance of the anthropologist, remain vital to Vd. Sharma’s diagnosis and
treatment.

Vd. Sharma assumes my alliance with the modern world, as well he should.
When he wants to explain to me the quality of concentration required in mixing
medicines he offers the example of Napoleon awaking from a nap just in time to
join the last man of his army. He says he is using the example of Napoleon “be-
cause you can understand, but our ṛṣi [usually translated as sages] were of that
type.” At another time he discusses the difference between empiricism and phi-
losophy as bases for medical knowledge. He tells me,

Now you are come from America.... Principles, line of treatment have been
always changing in your [medicine], according to research.... We appreciate
these things but there are some eternal principles, not changing; in Ayurveda there
are some eternal principles. So till those eternal principles are not understood, not
practiced, by theory or practical things, man cannot get good health.¹³

Once again Vd. Sharma identifies me with the modern, the progressive, against
which he defends the value of Ayurvedic “eternal principles.” When I ask
whether students of allopathy should learn Ayurveda, and vice versa, he ignores
or fails to hear the first question, perhaps because of its sheer unexpectedness,
and answers only the second. “Suppose what happens, for India what happens,
according just as you say, Ayurvedic students must be given modern education
also, compulsory, well what happens then...?” He foretells the undesirable
consequence that Ayurvedic students will “completely neglect Ayurvedic prin-
ciples.” For Vd. Sharma, whatever else I am, I am also a representative of
modern medicine, and of the modern in general. No matter how hard I try to
phrase my questions in a way that aligns me with the truths and interests of
Ayurveda, no matter how I aspire to the “native’s point of view,” I remain the
spokesperson for an opposing epistemology in all of our conversations.

Thus it is hardly surprising that the syntax in which I want to find Vd.
Sharma’s rejection of the anatomo-clinical method still reflects my own modern
bias of reality and its framework. My effort to draw a contrast between the meth-
ods of Vd. Sharma’s “ethnomedicine” with the methods of biomedicine is
thwarted in a very simple, and yet to the modem thinker, mysterious, way. Anat-
omy is an orderly representation of the reality of blood and muscles, bones and
guts inside the skin. But there is no similar binarism in Vd. Sharma’s practice of
Ayurveda. The doṣas are not contained; nor are they depicted or arrayed in a
modern display of natural phenomena. Vd. Sharma offers no enframing of the
forces of disease, no map of the person. For such an enframing he is only too
happy to refer me to modern-style medical colleges and younger “modernist”
vaidyas, excusing himself from the obligation to build modern models with the
explanation that he is of the “old school,” he is a “simple practitioner.” With
such phrases, he invokes the imagined chronology of Ayurveda’s march into the
modern world, while also firmly separating his own practice from that parade. He simultaneously asserts his tolerance of and his resolute nonparticipation in modern epistemologies. Whenever my scrutiny seems to require a split between representation and Ayurvedic reality (diagrams of doṣas, written records of prakṛtī), he deflects my attention toward those forms of Ayurvedic practice which he believes can satisfy this peculiarly modern need.

Whole Body, Half Body

In Indian cities, I can rarely find an address on the first try. Therefore, I am surprised and delighted to see a clearly lettered sign for Dr. Karnik’s clinic hung on the side of a building. The street that sports this sign is relatively empty, quiet, and tree-lined, without shops or merchants’ stalls. I pass through a gate into a small private courtyard. From there a door with another neatly printed sign leads directly into the doctor’s waiting room, where a patient sits awaiting his appointment. The door to the consultation room is closed. I sit down on a vinyl-cushioned couch. After a few minutes, Dr. Karnik opens the door and invites first the patient and then me inside. Dr. Karnik sits behind a desk. On the other side of the desk are two chairs. One of these is occupied by his assistant who takes notes and occasionally assists in the examination, and I occupy the other. The patients and their accompanying friends or relatives sit on the examination couch against the wall. If I were not there one of the friends or relatives would be seated in a chair. As it is, some of the friends and relatives have to stand. The consultation room is small and bright and spotlessly clean. There is a small sink on one wall where Dr. Karnik rinses his hands from time to time. Dr. Karnik treats by prescription only. He advises me that very good standardized Ayurvedic medicine is available from the Ayurvedic pharmaceutical companies.

It is very difficult to conduct a structured interview with Dr. Karnik. He frequently dismantles my questions rather than answering them. My first line of inquiry is his educational background. When I ask if he received an integrated education of allopathy and Ayurveda (as did many others of his generation) he replies, “The demarcation between modern medicine and Ayurveda is diffuse.” He goes on to explain the compatibility of Ayurveda and modern medicine. It is not until our second meeting that I realize that he almost always uses the term modern medicine in preference to allopathy. When I ask him whether the integration of Ayurveda and allopathy is desirable, he responds that at present it is not possible, but then he throws my term back at me. “What is allopathy?” he challenges. While I hesitate he supplies the answer: “Allopathy is world medicine.” It is, in other words, internationally applicable, even true. When I argue that culture conditions science if only in the choice of experiments, he concedes but then asserts that culture does not condition the results of experiments: these are “fact.” Very quickly every consultation and every phone call become fuel for the argument that there is no basic antagonism between Ayurveda and allopathy. Integration of the two will become possible as soon as Ayurvedic physicians are willing to adopt the experimental method. He assures me that the Ayurvedic ex-
amination and the modern examination are (or should be) the same. He reports a case that had been diagnosed by another doctor as appendicitis. When Dr. Karnik saw the patient he was able to rule out appendicitis because the patient had no appendix. In any system of medicine, he says, “appendix is appendix.”

Dr. Karnik downplays the importance of dosa theory. In diagnosis the identification of the disease is more central than the identification of prakṛti. He offers the analogy of two persons whose heights differ by a half-inch. If they are standing across the room from each other, he asks, “who can tell the difference?” The difference is real but negligible and difficult to discern. Between individuals with the same illness, Dr. Karnik claims, there can be only minor differences in prakṛti. The identification of disease, therefore, would seem to make the identification of prakṛti almost gratuitous. Dr. Karnik tells me that he has been criticized for performing allopathic diagnosis. Curious as to whether this criticism has been leveled by other Ayurvedic doctors or by allopaths, I ask, “criticized by whom?” He dodges: “That is another point; criticism is there.” More than once he aphoristically recites that if disease were not important there would be only three treatments, one for each doṣa.

In contrast to Vd. Sharma, Dr. Karnik makes no extensive inquiry into his patients’ diets. He asserts, moreover, that it is impossible to follow the Ayurvedic precepts of life in the contemporary world. Most people, for example, cannot rise early. When I ask if any fundamental principles of Ayurveda can be followed, Dr. Karnik discusses the changed environment, the prevalence of pollution, the noncircadian rhythm of modern schedules. While Dr. Karnik gives patients detailed instructions for ingesting the prescribed medicines, I did not once hear him make dietary suggestions. In fact, another practitioner confided to me that when he had told Dr. Karnik that he now required a diet diary of all his new patients, Dr. Karnik responded that that was all very well for making oneself look good and increasing one’s client load. In other words, in Dr. Karnik’s opinion, attention to diet has little or no diagnostic or curative significance.

He advocates a heavy reliance on modern diagnostic tools. There is a phone call from a patient with a “urinary tract problem.” An endoscopy has revealed a narrowing in the urethra which, Dr. Karnik tells me, Ayurvedic diagnosis would not have been able to detect. He mentions a student who developed a computerized form for piles diagnosis, yet provided no space on the form for a protoscopy. Piles diagnosis cannot be definitive without a protoscopy, Dr. Karnik states. His examination is far more pursuant of the signs of internal processes than Vd. Sharma’s dārsan. He spends at least as much time in examination as he does in talking to the patient. Moreover, he pays more attention to the affected parts of the body than to tongue and pulse. He peruses the results of laboratory results and X rays in the files patients bring from biomedical treatment centers. He tells me that before modern methods for revealing heart blockages were developed, an Ayurvedic doctor would have treated it according to symptoms. In this remark, “symptoms” becomes a gloss for visible manifestations of doṣa imbalance. “Now,” Dr. Karnik says, “everything is visual: I can see.” For Dr.
Karnik, Foucault’s interior gaze is the very essence of effective medical practice.

Dr. Karnik insists that the purpose of medicine is the same in all systems: to maintain health and to cure the patient. I confront him with the many literary and conversational assertions by other Ayurvedic physicians that Ayurveda is more concerned with prevention, while biomedicine is more concerned with cure. He counters that the World Health Organization has the largest known program for the prevention of disease. For him, the maintenance of health and the prevention of disease are equivalent. Yet for Vd. Sharma the maintenance of health implies also the persistence of joy, not only in one’s organs but in one’s mind and soul, the most transpersonal facet of one’s self. Vd. Sharma’s conception of the aim of medical treatment seems to follow one of the first sutras in the Caraka Samhita, which states, “That science [a translation of veda, which can also be translated, with less specific connotations, as knowledge] is designated as Ayurveda where advantageous and disadvantageous as well as happy and unhappy states of life along with what is good and bad for life, its measurement and the life itself are described” (Sharma and Dash 1976:5). Thus the aim of medicine seems to encompass longevity, happiness, and the good life generally, not only in Vd. Sharma’s perspective, but in one of the most respected Ayurvedic texts.

With such authorities apparently on my side, I also confront Dr. Karnik with the assertions made by other practitioners that Ayurveda is concerned with the whole body, while biomedicine is concerned only with the disease. Ayurveda, he counters, is “not a thing saying ‘whole body, half body.’ Everything is there.” In psychological ailments, he concedes, the whole body approach is essential, but in the case of a brain tumor, for example, a localized approach is necessary. He repeats, “Ayurveda is a total science; it’s not only one concept, whole body or half body . . . .” He is severely critical of those who say or imply that the diagnosis of a brain tumor is allopathy. “How can that be allopathy?” In other words, if an appendix is an appendix, surely a brain tumor is a brain tumor. I concede that in the case of a brain tumor the medical response is perhaps clear-cut: the doctor must operate to excise the tumor. Here Dr. Karnik interrupts me to say that in actual fact an Ayurvedic doctor does not operate: modern Ayurvedic surgeons have neither the facilities nor the skills to operate on a brain tumor. Disregarding this fact, which is crucial to his interests but peripheral to mine, I proceed with my line of questioning. I ask whether the medical response is not less clear-cut in the case of a patient who has 20 different complaints that do not add up to a clearly identifiable disease entity. Dr. Karnik replies that he teaches his students that a patient with 20 complaints is a “psychosomatic patient.” Sometimes he tells his patients not to ask the diagnosis, “because if the patient hears psychosomatic he thinks all the time psychosomatic and becomes more psychosomatic.” He also mentions that the medicine he is using at present for psychosomatic ailments has not been previously recommended for psychosomatic ailments.
Dr. Karnik identifies psychosomatic ailments with the class of ailments resulting from mana in ancient Ayurvedic texts. Vd. Sharma had also mentioned this class of ailments. In Vd. Sharma’s understanding, however, such ailments are not simply physical symptoms rising from mental disturbance but rather physical disorders rising from mental disturbance. For Vd. Sharma, the distinction between symptoms and disease, sign and referent, is, in any case, superfluous if not even spurious. Vd. Sharma states simply that “when man is affected, it will affect organs.” Dr. Karnik, on the other hand, has adopted the term psychosomatic for illnesses originating in the mind. For him, the distinction between symptoms and disease is both pertinent and genuine. Just before he tells me that he has been criticized for allopathic diagnostic procedures, he stresses that it is the disease that must be treated, not the symptoms. In my hypothetical patient, the 20 complaints are read as symptoms, signs of mental disorder, not manifestations of a disorder both physical and mental, whatever its origin. Many Ayurvedic practitioners and patients express the belief that Ayurveda is more effective for chronic diseases, while allopathy is more effective for acute diseases. Dr. Karnik, however, asserts that with the increase in life span, modern medicine will turn its vast resources toward the problem of chronic ailments. He predicts that over the next two decades, allopathy will advance beyond Ayurveda even in the treatment of chronic disease.

Dr. Karnik asserts that today, Ayurvedic surgeons perform only modern surgical procedures, although he confirms that these surgeons do perform unique preparations for surgery. When I repeat one surgeon’s assertion that it is essential for the surgeon to become intimate with his patients, Dr. Karnik says, “I’m supposed to be one of the senior persons in Ayurveda.” Therefore, foreigners and allopaths frequently ask him what Ayurveda has to offer that is different. “If I say doctor-patient relationship they say, we have that also. How much I am practicing doctor-patient relationship; how much he is practicing doctor-patient relationship: it is an individual thing.” He concludes that it is useless to practice an intimate doctor-patient relationship if you “miss the disease.” Clearly he believes that too many Ayurvedic doctors “miss the disease.”

Dr. Karnik seems to be a perfect example of an Ayurvedic practitioner who has been thoroughly modernized by his encounter with modern medical institutions and methods. He attributes his own expertise to the excellent “patient experience” he obtained in an Ayurvedic hospital where, in the outpatient department, he would see one hundred or more patients in a single day. A great number of physicians admitted to me that in such departments it is virtually impossible to pay close attention to dosa and prakrti. Throughout our time together I try to ask Dr. Karnik to define the uniqueness of Ayurveda. He persistently refuses, however, to construct this uniqueness. Unlike many Ayurvedic practitioners and authors he is not interested in promoting Ayurveda as a medical philosophy whose basic principles address the limitations of modern medicine. He is not tempted by neo-orientalist valorizations of Ayurveda as a holistic medicine, a discourse transcending the narrow objectivism of science. For him, medicine of any kind is a purely empirical matter: “everything is visual”; “appendix
is appendix." With the phrase "whole body, half body," Dr. Karnik effectively wrecks the assumed dualism of holistic versus atomistic perspectives on the body. In replacing the opposition of whole and part with the opposition of whole and half he does not so much create a new dualism as mark the meaninglessness of the original.

Frequently our conversations together devolve into arguments in which I am embarrassed to find myself attempting to save Ayurveda as a form of ethnomedicine. Dr. Karnik seems to delight in dismissing each example of Ayurvedic essence that I try to offer. Paradoxically, despite his allegiance to medical modernism, he undermines my anthropological modernism. For he will not permit Ayurveda to fill the empty category of tradition against which modernism wishes to define itself. He will not let me claim Ayurveda as a healing balm for modernity's excesses. If Vd. Sharma subverts the enframing of dosas and prakṛti, Dr. Karnik subverts the enframing of Ayurveda itself. For Dr. Karnik, Ayurveda itself has the status of science: therefore, it cannot be reduced to a scientific object, exhibited behind the glass of an anthropological display case.

Dr. Karnik's resistance to easy characterizations of Ayurvedic principles should not, however, be understood as a rejection of these principles. When I ask if Ayurveda provides basic concepts that can be adapted to the modern world, he is noncommittal; this, he says, "requires research." He goes on to say that Ayurvedic research is about drugs, rather than about basic concepts, because that is the "simple thing." Dr. Karnik repeatedly emphasizes to me that research, my own for example, must be controlled, quantified, documented. The problem with the aphoristic nature of the ancient texts is that "to read in between the lines is required." The Caraka Samhita (Sharma and Dash 1976), for example, stresses the importance of time and frequency and amount of dosage, without exactly specifying any of these for a given condition. I suggest that this information may have been passed from guru to student, and he agrees this "must have [been] done, but today it is not." I refer to the disruptive influence of foreign invasions on the continuity of Ayurvedic practice, and he responds, "If the gap is to be filled, how much work is required?" It is not that Ayurvedic principles are disproved by modern medicine; it is rather that Ayurvedic principles remain to be proven through experimentation and precise empirical measurement.

Nor does Dr. Karnik ignore doṣa altogether. After asking one patient if his gastric pain precedes or follows meals, he classifies the pain as pitta, and then explains to me that pain immediately after eating would be kapha, and pain four hours after eating would be vata. Moreover, although he makes a clear etiological distinction between physical and psychosomatic ailments, he does not make a rigid distinction between the lines of treatment for these two classes of illness. Dr. Karnik does not refer psychosomatic patients to a psychiatrist, as would an allopath. He mentions in passing that one patient with multiple complaints is suffering from psychosomatic illness. The patient is a man in his mid-thirties, very silent and downcast. Dr. Karnik feels his stomach for colonic tenderness, listens to his chest with a stethoscope, and checks for pain while the patient leans forward. A short while later Dr. Karnik tells the patient's relative, "Depression
is there." He tells the relative to bring the patient again after 15 days. He says, "I will see him and talk with him. It will help him. It's part of the treatment."

For Dr. Karnik, Ayurvedic practice is a vital science, endangered by drastic underfunding, ignorance of new diagnostic technologies, lack of quality research, and, perhaps it is fair to add, a tendency to rest in images of philosophical grandeur. Certainly he fiercely battles any trace of such images in my questions. Medicine, Dr. Karnik argues, is a matter of fact, not belief. He will not allow such Ayurvedic concepts as prakrti or the integration of psyche and soma to be used as evidence of an alternative worldview. He has no interest in being a witness for anthropology's proliferation of contrasting cognitive universes. He holds Ayurveda firmly out of reach of such dichotomies as holism and atomism, prevention and cure, positive health and allopathy. It is as if he suspects that the greater threat to Ayurveda is not so much the encroachment of biomedicine as the enframings of social studies, which would reduce Ayurveda from a science of health or a knowledge of long life to a sign of Hindu or Indian culture.

Toward the end of our final conversation, Dr. Karik informs me that I have forgotten to ask one thing: whether dosage should differ according to prakrti. In other words I have forgotten to ask one thing that is integral to my apparent anthropological agenda of essentializing the difference between Ayurveda and biomedicine. I have forgotten to ask one thing that might help me install Ayurveda in the anthropological display case. I say, yes, you are right—should dosage differ according to prakrti? Dr. Karnik smiles and offers a parable for an answer. If he is having 15 guests over for dinner he asks his cook to make a meal. The cook will make a meal suitable for all 15 guests despite their differences. "There is something like common food. There is something like average. Differences are very minute." I tell Dr. Karnik that many vaidyas have told me that the dosage definitely must differ according to prakrti. He smiles again and replies, "My common person [the cook], he has common sense."

All Westerners Want to Be Kapha

Dr. Shukla's clinic is on a busy street crowded with sidewalk retailers as well as a few glass-enclosed shops. The English sign for the clinic is relatively small and high above the thoroughfare, inconspicuous among the balconies and upper story windows but legible from the other side of the street. After spotting the sign, one must thread through the dense traffic to the opposite curb, brushing the fenders of cars as they inch forward, honking without cease. At the curb one must step gingerly between the wares of the vegetable wala and enter a dark passage. There one turns a corner and ascends a steep narrow wooden stairwell to a second-floor veranda with a wooden railing which serves one or two residences as well as the clinic. There one will often see someone asleep, wrapped up in a blanket on the floor. Moving toward the back of the building between the stairwell and a vacant area surrounded by wire fencing, one comes at last to the door of the clinic. Just inside the door is a narrow foyer, beyond that a small waiting room with a television, a puja shelf, a low table covered with magazines, and several chairs. A door to the left opens into the dispensary where Dr.
Shukla’s two pharmaceutical assistants prepare medicines. A door to the right opens into the air-conditioned, immaculate, and well-lit consultation and examination room where several chairs and stools are arranged around a table. One wall is lined with bookshelves interrupted only by another small puja where Dr. Shukla’s medical assistant, a young graduate from a local Ayurvedic college, lights a stick of incense at the beginning of the day’s office hours. Along another wall is an examination couch. A computer sits on a table in the corner. Behind Dr. Shukla’s chair is a small sliding glass window which opens on the dispensary and through which prescriptions are passed to his assistants.

I was once present when one of Dr. Shukla’s friends was joking to another about the clinic. He described the crowded street, the steep stairwell, the dingy hallway, and then the door opening onto the completely “modern” clinic. All three of the friends laughed, but Dr. Shukla seemed particularly gleeful. In fact, he seemed as slyly pleased with the contradiction as if he had intentionally designed the chaotic urban Indian scene in order to camouflage his own modernity. At the start of his book, Mitchell describes an “authentic” Egyptian mosque in the 1889 world exhibition whose facade opened into a coffee house (Mitchell 1988:1). The mosque exemplifies modernity’s project of architectural signification, the use of a building facade as a readable sign, not to mention its projects of the commercialization of authenticity and the separation of representation from reality. The street and building around Dr. Shukla’s clinic, however, resemble one of the labyrinthine urban scenes that frustrated European tourists in 19th-century Cairo who were “unable to find any point from which to take the picture” (Mitchell 1988:27). The thronged street and haphazardly arranged building offer no facade to announce the presence of a modern Ayurvedic clinic or of anything else for that matter. The modernity of the clinic is hidden, tucked away, lost between vegetable stalls and sleeping derelicts. What is interesting is that this inversion is, for Dr. Shukla and his friends, not a problem to lament or to repair, but simply a source of amusement, even delight. The friend’s description of the packed street and the ramshackle building is neither flatly visual nor value-free. This description carries the ironic connotation of a Euro-American image of India: density and dirt, poverty and disorder. The nonfacade becomes a facade of a stereotypically suffering India. Behind this facade are other contrasting layers of facade: the modern decor of the foyer, waiting room, dispensary, and consultation chamber. The signs for Indian backwardness and medical modernity jostle one another. The joke between Dr. Shukla and his friends is that the reality, the referent, remains elusive. It is as if the three of them play with one of modernity’s most sincere epistemes, the relationship between form and content, representation and reality. It is this subversive play that justifies Dr. Shukla’s expression of pure mischief. The clinic upsets the expected architecture of interior and exterior. Moreover, the upsetting of this architecture of interior and exterior extends from clinical space into personal space.

Dr. Shukla’s series of rooms seem to gradually lead the visitor from the public space of the street to the most private space of his innermost room, the consultation and examination room. Yet his office and his practice are anything
but private in the late-20th-century North American sense of the word. Patients rarely come to the clinic alone. If they are not accompanied by family members they are accompanied by friends. Frequently everyone in the group consults the doctor about his or her health problems in turn. When one person’s case is discussed, the others chime in with additional information. Besides friends and family of the patient, there is always an assistant physician, at least once a week an observing physician, and occasionally, for extended periods of time, social researchers like myself. My own acceptance into this context, given sufficient personal contacts, is immediate and complete in a way that takes me by surprise. The experience is a little like leaning heavily on a door only to have it open without resistance. My presence often goes unexplained. Yet none of the patients (with the exception of the non-Indian patients) seem hesitant or embarrassed to discuss the details of their diet, physical complaints, and health worries. Sometimes they glance at me as they speak, partly addressing to me apologies about their lifestyle or concerns about their condition. During any given consultation, the health of persons mutually known but not present may also be discussed. Thus what at first seems to be a private space, divided from the waiting room by a bolted door and from the dispensary by a window which slides open and shut, eventually comes to seem oddly public.

In Vd. Sharma’s dispensary and Dr. Karnik’s clinic, patients are often accompanied by friends or relatives. Yet the confusion of public and private is more problematic for me in Dr. Shukla’s clinic for the simple reason that his consultations more often include the kinds of information I am conditioned to consider private. When Dr. Shukla asks one woman about her late-afternoon depression, her daughter interrupts to say, “She’s very busy earlier in the day, then she’s free. The moment she’s free she gets depression... You can tell when she is depressed by the shape of her mouth... She pouts.” From the standpoint of biomedicine, depression might be labeled one of the most private illnesses. A primary characteristic of depression, according to the authoritative biomedical text on psychological states, is social withdrawal (American Psychiatric Association 1987). In Dr. Shukla’s clinic, however, depression and many other emotional states are a matter not only of familial commentary but of more general roundtable discussion.

If Vd. Sharma’s diagnosis privileges darśan, and Dr. Karnik’s diagnosis privileges modern technologies, Dr. Shukla’s diagnosis seems to privilege conversation. He may spend from 30 to 40 minutes or longer with a new patient, inquiring into health history, including childhood illnesses and allopathic medicines taken in the past, diet, state of mind, and expectations of treatment. The examination of the patient, which routinely includes pulse, weight, blood pressure, tongue, and attention to affected parts of the body, usually takes just a few minutes. He pays close attention to the results of modern laboratory tests. For example, he chooses not to begin treatment of a patient with fluctuating blood sugar levels until he receives the latest report of the patient’s blood sugar. It is clear from his conversation, however, that he uses such information less to assign the patient to a particular disease category than to make a more total assess-
ment of the patient’s condition. He tells the above patient, for instance, that he does not seem like a typical diabetic, and that many factors, including diet, smoking, and drugs, may be affecting his blood sugar.

Dr. Shukla’s conversation ranges as widely through the language of biomedicine as through the language of textbook Ayurveda. He freely translates Ayurvedic disorders into allopathic disease categories, glossing amavat, for example, as rheumatoid arthritis. He often explains ailments to me in terms of organ dysfunctions, contrasting digestive problems centered in the duodenum, for example, with digestive problems centered in the stomach. The medical records of Dr. Shukla’s patients include lists of physical and emotional complaints, chronologies of major diseases, results of examinations and outside laboratory tests, lists of medicines administered (organized in categories of herbal compounds in tablets, herbal compounds in powders, and metals), and lastly a track record of improvement registered by a series of pluses and minuses next to each complaint. Dr. Shukla is interested in developing an even more systematic, streamlined, and computerized form to assure that he makes no omissions during a consultation. Dr. Shukla’s language and documentation seem therefore quite consistent with a modern ordering of information.

Missing from Dr. Shukla’s records, as from those of Vd. Sharma, is any discussion or listing of doṣa and prakṛti. Also missing is another component frequently and strikingly interwoven into Dr. Shukla’s interrogation of the patient. This component is a moral discourse on proper living habits, that is, not simply diet and seasonal adjustments but attitude and ethics, the whole complex nexus of relationships to society and to oneself. A handful of stories can illustrate this discourse. A woman in her twenties comes with her parents. For several years she has eaten only fruit and milk. Dr. Shukla probes, “Only because of some health problem you are taking or something is there in your mind? There must be some reason for suddenly going on fruit and milk.” The woman is quiet; she smiles slightly and looks into her lap. He asks, “Have you tried to ask yourself, why it is happening?” When he learns that she is a student of economics he quips, “So you are economizing your food.” He tells her he cannot start treatment unless she is willing to change her diet, and asks, “What are you going to choose, injection or diet?” Later he comments to me that there must be a psychological reason for her strange diet. Gradually, he says, it will come out. Maybe next time or the time after that. Perhaps, he speculates, someone in her family made a remark about her eating the family’s food without contributing to its income.

Another woman comes to the clinic because of infertility. Dr. Shukla can find no physiological reason for her inability to conceive. An allopathic doctor has prescribed sedatives and antipsychotic drugs for her mood swings. At the last visit, Dr. Shukla asked her to discontinue these medications but in the interval she experienced a bout of anxiety and began taking them again. Dr. Shukla tells her, “To allow a little worry might be part of your treatment. If you look for your escape from medicines it is not going to help you.” He warns her, “If you will not be able to stop these medicines I will not be able to go further with you.” He goes on to tell her that her system is depressed and needs not sedation.
but stimulation. He tells her that only after she has lost weight and discontinued the sedatives will he be able to focus on the problem of her infertility. He reiterates that she may have to experience a little anxiety as part of her treatment. He will not permit her, however, to endure anything as extreme as acute insomnia. He tells her to feel free to call him whenever she is feeling anxious.

A patient comes to report that he has been free of insomnia for four months without the use of sleeping pills. Dr. Shukla says, “That’s a good achievement, yes?” and then asks about his general well-being. The patient says that his outlook has improved. He feels that he is more philosophical about life. Dr. Shukla responds, “I want you to think philosophically also. . . . That is also a part of treatment.” Later in the session, Dr. Shukla advises, “Try to be like a Buddha, not that you have to be a Buddha, but follow what Buddha has said.” They agree that in the city it is difficult to live like a Buddha. Dr. Shukla says, “By going to Himalayas everyone can remain quiet.” Staying in the city and remaining quiet “is a bigger challenge.”

A large man comes to be treated for weight and other complaints. He is concerned about his tobacco habit. He used to be a chain-smoker, 60 cigarettes a day, he tells us. He quit smoking without difficulty. Yet he cannot seem to give up tobacco. Dr. Shukla suggests that he reduce his tobacco intake from six times a day to four. Then he brings up the subject of the patient’s childhood. The patient had too many responsibilities thrown on him and yet “still no confidence.” Dr. Shukla says, “There are people who carry the whole burden.” This sympathy prompts the man to tell a story of loaning his brother-in-law money. He is bothered by his brother-in-law’s ingratitude. Dr. Shukla advises him, “If you do good, forget it.” He reminds the patient that he does not remember the times he gives a beggar two rupees. Why, then, should he remember a time when he gave a relative two lakhs of rupees? Dr. Shukla asks, “The minute you expect anything you suffer. . . . What is success?” He emphasizes that peace of mind is the most important thing. The patient confides that he has trouble controlling his temper. If he takes less tobacco his “nature becomes nasty.” Dr. Shukla says that if he must express anger it should be “artificial anger,” required by the situation, and not “natural anger.” The patient attributes his anger to physical problems such as his high blood pressure. Dr. Shukla replies that these are simply excuses. If the patient can be in command of his business and his diet, then he can also be in command of his temper. He recommends that the patient spend 15 to 20 minutes alone every day. He tells him to go to the ocean, sit in his car, watch the waves, and “talk to your driver about his problems.” The patient listens, then mentions on his own behalf that he does not party or drink. Dr. Shukla tells him to go to the park and walk on the beach, not for the exercise, but to “see the beggars, smell the stink.” In this way he will reach some peace, some perspective, about his own problems.

Dr. Shukla tells me the story of a heart patient who has a shop in the neighborhood. He refuses to take care of his health. He will not stop eating salt or “junk food.” Every day he buys fried food from the stalls on the street corner. He worries incessantly about money. Every year he goes into the hospital for one or
two months because of “right ventricle failure.” Still he continues his destructive lifestyle. Dr. Shukla predicts that he will die on the streets someday.

This is Dr. Shukla’s discourse of health, a discourse that circles out from prakṛti and disease, diet and family relations, to a total philosophy of life. Dr. Shukla demands of his patients not merely the compliance of taking their medications, but a complete moral attention to their actions and mental-emotional states. The woman who eats only fruit and milk must free herself from her sense of indebtedness to her family. She must stop using her body as a ledger in which to balance the family accounts. The woman who is infertile must face her anxieties. The man who has recovered from insomnia must practice the philosophical detachment of Buddha. The man who is addicted to tobacco must learn to loan out two lakhs of rupees to his brother-in-law with the same equanimity with which he hands over two rupees to a mendicant. Meanwhile, the man who worries about money and eats junk food will fall dead in the street as an example to the others. A person who wants to be healthy should not escape into antidepressants or Himalayan caves but learn to remain “quiet” in the center of city life, in the center of his or her anxieties. A person who wants to lower his blood pressure should contemplate the vastness of the sea and of other people’s problems. What in a contemporary North American context might have been an unearthing of the intimate psychological secrets of illness opens out into a declaration of moral, and even religious, principles. Dr. Shukla might as well be quoting Buddha, or Kṛṣṇa in the Bhagavad Gītā, when he argues that expectations lead to suffering, and disregard for reward leads to peace. My initial discomfort at eavesdropping on a private conversation begins to seem misplaced. Just as Vd. Sharma’s “going deep” penetrates not so much the patient as his or her network of relationships with the social and natural environment, so Dr. Shukla’s interrogation investigates not so much the hidden folds and foibles of the personality as universal problems of human action.

Dr. Shukla requires further moral courage from his patients: “faith” or “confidence” in Ayurveda. He first discusses this faith with me while seeing a patient with a very extreme case of eczema. He examines the sore on her leg with a magnifying glass. He tells me that the steroids the woman had been taking for her eczema had only made it worse. He also believes a leg operation affected the “subdermal layer.” Dr. Shukla practices with this patient, as with all his patients, a careful and expert interior gaze. After that he talks to me of faith. The evidence of this patient’s faith is that since she began Ayurvedic treatment she has taken no steroids. He recalls another patient with similar faith. This patient asked him one day if she could begin to eat salt again. He had forgotten that he casually remarked to her ten months earlier that restricting her use of salt would aid in her healing. Patients with such faith, he assures me, make treatment easier.

He goes on to explain that Ayurvedic treatment with patients who take allopathic drugs involves more trial-and-error since the specific effects (including toxicity) of these drugs are often unknown. Because of the difficulty of treating patients who bounce between allopathy and Ayurveda, Dr. Shukla sometimes “tests” patients for their faith in Ayurveda. One woman comes to the clinic twice
in three days. She says of the pain from her eczema, “I can’t bear it.” An allopathic doctor has given her an ointment. Dr. Shukla tells her she can keep using it but then adds, “You are taking too many medicines. I don’t know where this will lead.” At present the woman is taking antibiotics and steroids as well as Dr. Shukla’s medicine. She volunteers, “I should not go to allopathic doctor.” Dr. Shukla warns her that Ayurvedic treatment will take longer. The woman indicates that she is resigned to a longer treatment. Reluctantly Dr. Shukla prescribes some medication but then continues to voice skepticism over her treatment, saying, “And you are working. You are continuing to work which I cannot stop.” The woman says that she has taken enough allopathic medicine but then asks abruptly if she should go to a skin specialist. Dr. Shukla answers, “You need that in a way. But he will give you steroids only. He cannot give you anything else.” Finally he tells her, “You choose one,” that is, allopathy or Ayurveda, and then reiterates, “In present situation with your asthma and this [eczema] flaring up you must choose. Ayurveda will take more time.” Again the woman says she is willing to take the extra time. Dr. Shukla, however, becomes even more resistant. He tells her to get a recommendation for a dermatologist from her general practitioner and to follow his treatment plan. When the “problem is less severe” she can return for Ayurvedic treatment. He stresses that he cannot offer acute relief, but that the dermatologist cannot offer long-term cure. After she has left he tells me that “in a way” he has been testing her sincerity. He is not sure she is committed to Ayurveda. One patient initially tries to hide the fact that he has been to an allopathic heart specialist. After he leaves, Dr. Shukla tells me that the man claims to have confidence in Ayurveda but actually does not.

Ayurveda is treated by anthropologists as an indigenous system of medicine that is deeply ingrained in Indian society. Several anthropologists have argued that Ayurveda has survived, despite the enormous competition from biomedicine, precisely because it encodes deep-seated cultural experiences and values that extend beyond medical diagnosis and cure. Yet Dr. Shukla spends a good deal of his consultation time educating his patients about Ayurveda in order to sell it to them. In a sense he is forced to essentialize Ayurveda, to package it, simply in order to practice it. Dr. Shukla, however, cannot count on invoking a set of cultural essences with which Ayurveda is supposedly suffused. Instead he must improvise cultural essences, drawing on whatever scraps of ideology are at hand, ranging from orientalist-reminiscent constructions of Indian spiritual wisdom to international trends of holistic health. At a time when the confidence of urban and many rural Indians seems to have turned away from Ayurveda toward biomedicine, Ayurvedic physicians employ different strategies to win it back. Dr. Karnik attempts to erase the differences between Ayurveda and biomedicine. Dr. Shukla, however, assembles those differences into a marketable commodity.

Dr. Shukla teaches his patients that Ayurveda is a systemic approach to health. During the session with the anxious, infertile woman he explains to her that her “whole metabolism has to improve.” He builds an analogy with the of-
office fan, which has a mysterious problem. To start the fan running one must first manually turn the blades. Each part of the fan is intact; there is no mechanical reason for its difficulty, but there is “some small problem somewhere in the system.” Similarly there is no physiological reason for the patient’s infertility; there is, rather, some small problem in her system. Although Dr. Shukla compares her system to a fan, he is arguing that illness is not a mechanism but a systemic disturbance. The patient whose faith in Ayurveda must be tested is told at one point that her body is not “some machine.” He tells the infertile woman, “If I were going to treat all cases of infertility in the same way then there is no difference between allopathy and Ayurveda.” Dr. Shukla teaches his patients that while allopathy isolates disorders and counters them with standard remedies, Ayurveda links disorders to a complex system and adjusts that system with particularized remedies.

Another patient complains of some discomfort as a result of taking Dr. Shukla’s medicines. He responds, “See, we don’t have a suction machine to take things out. Things have to go out of your system in some way.” He tells her that as an Ayurvedic doctor he does not sanction drastic measures. He says, “Here we are trying to change the whole system.” Then Dr. Shukla and the woman’s husband discuss the importance of faith in Ayurveda. Without faith, the husband says, “you should not come.” Dr. Shukla predicts that gradually the literate class will return to Ayurveda. The conversation turns then to Ayurveda’s assets and liabilities. The husband mentions that Ayurveda requires more time. Dr. Shukla responds, “Normally you would feel Ayurveda is slow. I will strongly deny this thing.” He notes that illness arises through processes that have evolved over many years. He argues that when we single out a specific disease “we are not identifying our health as such; we are identifying some manifestation.” Acute treatments such as antibiotics may suppress a given manifestation. “But still disease is being changed to something else.” According to Dr. Shukla, he is fully capable of treating acute illness. “But I am not doing [that] because my śāstra [here probably translatable as set of principles] is not allowing me to do that.” Ayurveda’s advantage over allopathy is its ability to address the systemic disorder and not simply to suppress the manifestation. Acute Ayurvedic treatment would undermine the systemic principles that give Ayurveda its unique value.

In one conversation, Dr. Shukla asserts that Ayurvedic research should be less oriented toward specific diseases and drugs and more oriented toward “therapies.” At present such a development is impossible; ultimately, however, he argues that it is inevitable. He explains that understandings of disease are already shifting from “infections” to “metabolic disorders” or “degenerative disorders,” in other words to more systemic models. He seems to mean that the understandings of disease are shifting not only in Ayurveda but in biomedicine as well. While Dr. Karnik foresees that biomedicine’s attention to chronic illness will efface the last apparent stronghold of Ayurvedic uniqueness, Dr. Shukla hopes that this attention will help to legitimate Ayurvedic uniqueness.

Unlike Dr. Karnik, Dr. Shukla does not compartmentalize physical and psychosomatic disorders. After the departure of one patient with chronic bowel
problems and several other complaints, Dr. Shukla informs me that modern medicine would label his case “IBS,” irritated bowel syndrome. Since biomedicine recognizes no physiological cause for IBS it treats it as a mental (that is, psychosomatic) disorder. Allopathic treatment therefore targets the nervous system. Dr. Shukla, however, will treat the problem as simultaneously physical and psychological. For Dr. Karnik, multiple complaints always signal a psychosomatic problem. For Dr. Shukla, however, multiple complaints are understood as the many manifestations of a systemic problem that is both physical and psychological. Similarly, Dr. Shukla suggests that the Ayurvedic attention to the whole person should result in a more sensitive doctor-patient relationship. We discuss my observations of an Ayurvedic practitioner whom he also knows. He says that she lacks the “human touch.” Like Dr. Karnik, he argues that this is a matter of personal temperament. Yet when I comment that biomedical education seems to undermine the human touch, Dr. Shukla says that he is more disturbed when an Ayurvedic physician lacks this touch because Ayurveda teaches the doctor to examine the affected part and the patient, the body and the mind, the illness and the dosa.

Ayurvedic literature published in English over the last three decades is a medley of ideological voices. At different moments the authors seem to be involved in selling Ayurveda to North Americans, Europeans, and cosmopolitan Indians either as holistic medicine, taking advantage of the international trend toward holistic health care, or as a source of new drugs for biomedicine, taking advantage of the endless expansion of the biomedical pharmaceutical repertoire. The literature often highlights Ayurveda’s emphasis on positive health and preventive care, its use of nontoxic herbs, and its concern with the whole person, while paradoxically also playing up the wonder drugs it can offer for certain biomedically defined diseases. Biomedical practitioners who take an interest in Ayurveda are also attracted either by the possibility of new drugs (witness the booming business of marketing Ayurvedic medicines for pharmacists and allopaths) or by holistic wisdom (see in particular Lele 1986). Dr. Shukla himself embraces this paradox, eloquently defending Ayurvedic principles while also taking an avid interest in research on Ayurvedic drugs. Yet he is critical of allopaths who court Ayurveda only to appropriate its medicines. It is significant that because of my own biases and background in health care I am more responsive to Ayurvedic philosophy than to Ayurvedic pharmaceutics. Dr. Shukla freely admits that with me and with other cultural anthropologists he is more apt to discuss Ayurvedic principles, while with biomedical researchers he is more apt to discuss physiological processes. Dr. Shukla is in the difficult position of both appreciating the interest in Ayurveda stirred by biomedical trends and protecting Ayurveda from being absorbed by those very same trends.

Dr. Shukla’s promotion of Ayurveda as a systemic medicine must be understood, at least partly, in the context of the increasing demand for such medicine among European and North American consumers. Yet how well his practice of Ayurveda in fact matches this demand for holism is partly revealed when a U.S. woman visits his clinic. Unlike the Indians, who must be educated about
Ayurveda, she has already read at least one book, by another North American, on the subject. Indian patients who have some education about Ayurveda have certain expectations of Ayurvedic cure. They commonly believe, for example, that Ayurvedic medications have less dramatic results and less negative side effects. The U.S. woman, however, has expectations not just of Ayurvedic cure but of Ayurvedic diagnosis. After her first visit, for example, she confides in me (I have offered her the extra mattress in my flat) that she is surprised Dr. Shukla has not asked her about her psychological history, which she is sure is central to a correct diagnosis. Moreover, before she first arrives in the clinic she is already convinced from what she has read that her constitution is predominantly vata. After examining her, Dr. Shukla comments to me that she has a very “peculiar pulse.” Then he says, “It’s very rare that you find a pure prakrti.” I ask, “Is she a pure prakrti?” and he says yes, in his opinion, she is almost totally pitta. Out of earshot on the examination couch, where Dr. Shukla’s assistant is taking her blood pressure, the woman asks with interest if she is vata. Dr. Shukla misunderstands and comments to me that “every Westerner wants to be kapha.” When the woman understands that he has pronounced her pitta, she asks, “What’s that? Fire?” He answers yes, but then turns to me and confides that he prefers not to refer to the dosas as wind, bile, and so forth. Upon taking Dr. Shukla’s medication, the woman experiences almost immediate relief from two of her most pressing complaints. She remains mystified, however, about her diagnosis as pitta. When she tells him again just before she leaves India that she seems to have all the characteristics of a perfect vata, he simply says, “We will see.”

What is striking about Dr. Shukla’s comment that all Westerners want to be kapha is not that Westerners want to be predominant in the dosa usually glossed as phlegm. What is striking is that Westerners want to be predominant in some dosa or other, that they want to be categorized as a particular prakrti. I never observed a single Indian patient express curiosity, let alone desire, about his or her prakrti. In his remark, Dr. Shukla seems to be commenting on a specific North American craving for individuality served up in an Ayurvedic recipe. The “Westerner” transforms prakrti from a particular relationship with foods and climate to a personality trait. The U.S. woman has trouble accepting herself as pitta because she already has recognized herself within the complex of adjectives associated with vata. The book she has read about Ayurveda (Frawley 1989) reads like many other self-help books published in the United States. It presents Ayurveda as a simple, elegant, and well-organized system. It translates Ayurveda into terms that are readily assimilable by experienced consumers of holistic health. Chapter 3 is entitled “Constitutional Examination: How to Determine Your Unique Psycho-Physical Nature”; chapter 5, “Balancing the Humors: The Ways of Holistic Living”; and chapter 6, “Ayurvedic Diet: Personalizing Your Dietary Regime” (Frawley 1989). The book may be used as an Ayurvedic self-healing program or as preparation for visiting an Ayurvedic practitioner. My intent here is not to criticize the book itself: translations of Ayurveda into the terms of North American holism are inevitable, and as such translations go, this
one is clear, inclusive, and respectful of intricacies. My intent is rather to locate the U.S. patient’s interest in her prakṛti within late-20th-century formulations of American individualism which have been discussed by several social researchers (such as Bellah et al. 1985 and Cox 1977).

In the United States, the enthusiasm for holistic health care exists within a context of the valorization of the individual who is to be developed to his fullest “human potential” through elaborate and eclectic self-attention. Here holism implies an in-depth mining of the person as an interior space. This private identity of the modern individual, which provides the necessary counterpoint to his or her civic role, is the subject not only of modern autobiographies and diaries (see Chakrabarty 1992) but of modern psychological discourse as well. Such a subject increasingly imagines healing as the exploration and eventual exteriorization-expression of the individual’s true inner self. The movement toward a more “humanistic” medicine acknowledges the need to involve this inner self—with all of its motives, fears, dreams, and ambivalences—in the treatment of illness.

Therefore, it is not surprising that after the first day or two I feel intrusive while in Dr. Shukla’s office only during the visits of North American, European, or Australian patients. Inevitably I feel compelled to ask these patients for permission to be present during their examinations and consultations. Even after they consent to my presence, sometimes protesting their openness, I feel or imagine a mutual embarrassment. The psychological problems of these patients, unlike those of the Indian patients, rarely open out into social and moral dilemmas. The U.S. woman confides that as a child she had been left to eat only cold food out of the refrigerator. She also volunteers that she suffers from chronic anxiety. An Australian man reveals that his physical problems began with a relationship break-up. He also discloses that he is subject to emotional suppression occasionally erupting in violent fits of anger. Psychological problems are smoothly traced to social sources but nonetheless interpreted as inner traits following formulaic processes.

Dr. Shukla is in the business of convincing Indians that they need the systemic medicine that consumers in European-based societies are beginning to clamor for. At the same time, however, he is in the position of denying Westerners the prefabricated humoral identity they seem to crave. A European man with a handful of chronic complaints visits Dr. Shukla from a nearby ashram. Later the same day, when advising an Indian patient to spend more time in quiet contemplation, he mentions the European. He throws out a comment to the effect that foreigners in India practice meditation, yet ironically Indians themselves do not. Then he adds that actually sannyas (the ascetic’s vow to relinquish worldly ties) “is easier.” It is more difficult to be a householder, care for your family, “face the music.” In the international market Ayurveda may seem to advertise a preintegrated identity, just as Hindu ashrams may seem to advertise a retreat from society. But in fact, for Dr. Shukla, Ayurveda, like meditation, is less an item to be purchased than an ethic to be practiced.
Ironically, Westerners already seem to have the faith that he must continuously test for in Indians. Yet that faith in Ayurveda is also an expectation that Ayurveda will confirm their individuality. Dr. Shukla promotes Ayurveda in terms that resemble European and North American holism, yet he practices Ayurveda in terms that defy that holism. For holistic medicine is marketed toward those who imagine that the road to health is at the same time a road to individuation. For such individuals medicine is entangled in self-description, in self-reification, in self-enframing. As Arney and Bergen have pointed out, the fashion in holism and “humanistic” medicine disciplines patients to be true to “their own nature” (1984:138). Similarly, Baudrillard has suggested that contemporary consumerism itself fosters the notion of being true to oneself: “Traditional morality only required that the individual conform to the group; advertising ‘philosophy’ requires that they now conform to themselves” (Baudrillard 1988:13). When it appears on the psychological self-help grocery list, holistic treatment easily becomes a medicalization of life choices and trajectories. Dr. Shukla’s treatment, however, is better understood as a moralization of medical trajectories. If there is a “nature” to which his patients must be true, it is transpersonal, unencompassed, detached from personal position and interests. In fact, it is less a nature than a complex of choices, a moral direction.

During one conversation, Dr. Shukla comments that one of his “worries” about my research is what he describes as my “fascination” with Ayurveda and perhaps with India more generally. He is reluctant to say more for fear of being misunderstood. Perhaps, however, it is fair to free-associate my “fascination” with the eager self-diagnoses of his U.S. patient. The danger of foreign consumers of Ayurveda, whether seekers of a health that is conflated to identity, or sympathetic social researchers, is our readiness to interpret Ayurveda as a new commodity to satisfy our own cultural hungers.

Inverting Modernity

Since the early part of this century, the proponents of Ayurveda have defended it from the encroachments of biomedicine on many platforms. On one platform they defend it as an embodiment of certain eternal truths. On another they defend it as a symbol of national identity. On another they defend it as a useful addendum to biomedicine. On yet another they defend it as a solution to the atomistic excesses of modern science. Each of these tactical responses to biomedical power are evident, alone or in mosaic, in the three medical practices considered here. All three doctors, to a greater or lesser degree, engage in a dialogue with modernity, not only in their interviews with me but also in their medical practices. Vd. Sharma, both imagining and perceiving my complicity with empiricism and with diagrammatic models of medical treatment, preaches the importance of absolute principles and diachronic narratives of medical treatment. Dr. Karnik, imagining and perceiving my complicity with a modern desire for the counterbalance of tradition, insists on the evaluation and development of Ayurveda along strictly scientific lines. Dr. Shukla, imagining and perceiving my and his non-Indian patients’ complicity with holistic fashions and touristic
romanticism, offers an Ayurvedic cure that requires not consumption but commitment. These practitioners undermine my three assumptions—that medical phenomena can be mapped onto the person, that local medical knowledge can be isolated and defined, and that illness is a private matter—sometimes unwittingly, but sometimes quite deliberately. In a sense they offer me no basis on which to make the typological comparisons I try to make: with Vd. Sharma, I fail to compare concepts of person; with Dr. Karnik, I fail to compare ethnomedical paradigms; and with Dr. Shukla, I fail to compare brands of holistic humanism.

These practitioners’ statements to me are not transparent expressions of their conceptions of medical phenomenology but rather political gestures. They speak not only to their patients and to the anthropologist but also to allopathic doctors, to government agencies (who are responsible both for valorizing Ayurveda as Indian and for prioritizing allopathy over Ayurveda), to their Ayurvedic colleagues, and to European or North American consumers of imagined Asian wholeness. All these interlocutors have their ghostly presences in interviews and to some extent in patient consultations. These Ayurvedic physicians thus address themselves to such wide-ranging forces and discourses as biomedical science, national identity, and neo-orientalism. What is at stake in their discourse and practice is not so much that Ayurveda might be lost as a cultural form. The very construction of Ayurveda as a cultural form fits rather well into a project of biomedical dominance, as does the construction of Ayurveda as a local version of the interior gaze. The first allows biomedicine to bracket Ayurveda as merely a cultural practice; the second allows it to absorb Ayurveda as a subordinate medicine, a source of a few drugs and a few insights. What is at stake, rather, is Ayurveda’s subjection to the domination of enframing epistemologies.

It is not that there is no trace of the modern interiorization of the person in the practices of these three physicians. The files of Vd. Sharma’s patients hold X-ray films of their chest cavities. For Dr. Karnik, the instruments that survey the interior of the body are the final diagnostic arbiters. Dr. Shukla discusses illness as readily in terms of physiological dysfunctions as in terms of dosa imbalance. Nor is there a total disregard for the notion of privacy. Vd. Sharma is careful to tell me that he can close the screen between his consultation alcove and the rest of the room, even though he rarely does. Dr. Karnik’s and Dr. Shukla’s waiting rooms and examination rooms are definitively separate. Yet within these seemingly private spaces the discourse often has a distinctly public character—social, moral, and even political, in its references to the contest between allopathy and Ayurveda. The anatomo-clinical method, the positivist representation of an objectivized reality, and the dualism of inside and outside are not rejected but rather subjected to a variety of sometimes calculated, sometimes casual maneuvers that subvert, invert, and otherwise play with the modern episteme.

In urban Ayurveda today, the interiorization of persons and the enframing of medicine are epistemological moves that remain partial and ambivalent. Prakash has noted that the introduction of science in colonial India became ensnared in the contradiction that the Indians who were represented as objects of
scientific knowledge were also recruited as co-knowers of scientific knowledge (1992). That contradiction still echoes in Ayurveda today. Even if these three practitioners allow the modern exhibitionary gaze to focus to some extent on Ayurvedic patients and illnesses, they are reluctant to allow it to focus squarely on Ayurveda itself. Ayurveda as cultural difference will not be diagrammed by Vd. Sharma, defined by Dr. Karnik, or packaged for a North American market by Dr. Shukla. Ayurveda is not so easily reduced to exoticized ethnomedicine or the latest brand of commodified holism.

Notes

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1. Each of these terms has certain political ramifications in India, particularly when used by practitioners or proponents of a certain type of medicine. Modern medicine is used primarily by practitioners and allies of biomedicine, and implies that other types of medicine are premodern. Allopathy is used primarily by practitioners of Siddha, Unani, homeopathy, and Ayurveda; it connotes a medicine that is more disease-oriented than health-oriented. Biomedicine is used primarily by social researchers and suggests a medicine that is based in biological science. It is, on the face of it, the most politically neutral term in the contest among medical practices, though not necessarily in the construction of modern knowledge. In this article, I will use all three terms depending on the context.

2. Consideration of precolonial Ayurvedic education is outside the scope of this article. It would be a mistake, however, to assume that the guru-disciple structure observed in the 19th century reflects a continuous tradition uniform across India and dating from Vedic times.

3. The use of the word modern to even fuzzily denote a complex of epistemological practices is problematic. Even the most critical usage of the word tends to hold vestiges of evaluative and chronological connotations. It is also questionable how completely its meanings in academic discourses can be insulated from its meanings in development and world-capitalist discourses. In using this term I want to at least acknowledge its strange tautological twist, for it is the modern episteme itself which is responsible for constructing the dichotomy between the modern and the premodern or traditional. Despite this awkward (il)logic, it seems that we can no more talk ourselves entirely outside of the modern than we can talk ourselves entirely outside of signification (see Derrida 1976) or entirely outside of history (see Chakrabarty 1992). Substitute terms such as the purely geographic European, or the more specifically historical post-
Enlightenment are no more politically neutral than modern. It would conceivably be appropriate to use the phrase colonial/neocolonial episteme for a project of knowledge that has been at the same time a project of colonization/enclosure. Such a usage, however, would require a broad understanding of colonialism as extending beyond political economy. Moreover, colonialism is not unique to Europe where the modern modes of knowledge analyzed by Foucault, Fabian, Mitchell, and many others originated. In this article, therefore, I will continue to use the words modern and modernity under protest and under erasure.

4. The interviews and conversations on which this article is based were conducted in English over a period of three months. The interview with Vd. Sharma was taped; the other two were not. While the interviews covered the same range of topics in all three cases, they were conducted in an informal open-ended way in order to allow the particular concerns of the three practitioners to emerge as fully as possible. The names used for these practitioners are pseudonyms.

5. Lata Mani’s (1989[1987]) work has made it amply clear that the strategies of Indian reformers were susceptible to influence by the orientalist agenda.

6. I use the term syncretic reservedly since it tends to imply a mechanical mixture of two or more belief systems. Taussig’s (1987) account of a constant trade in images between colonizer and colonized is a more apt description of the way that Ayurveda is continually reinvented through a reworking of biomedical, orientalist, and other colonial/postcolonial discourses.

7. The issue of whether or not Ayurveda qualifies as a science in the European post-Enlightenment sense of the word is outside the scope of this article. For anthropological discussions of this issue from various perspectives, see Leslie 1976; Obeyesekere 1992, 1982; Trawick 1981; and Zimmermann 1987.

8. Examples in the literature include Ghanekar 1962; Savnur 1984[1950]; and the many doctors consulted in the preparation of the Madras government report on Ayurvedic medicine (Government of Madras 1923).

9. They also, of course, resemble the anthropological descriptions of various ethnomedicines, including Ayurveda. In a forthcoming paper (Langford n.d.), I explore the relationship between medical anthropological discourses and the discourses of holistic health movements.

10. See, for example, Athavale 1977; Dhyani 1987; and Thakkur 1965.

11. The Hindi/Sanskrit word most frequently given as a translation for English “person” is vyakti. It is far from clear, however, whether the two terms cover the same semantic terrain. Vyakti is also given as a translation for English “individual.” Yet in English, “individual” has a definite modern tinge, conjuring up the cluster of rights, motives, interests, and responsibilities associated with citizenship in a nation-state. “Person,” on the other hand, is less specifically connotative, more encompassing, more presumably capable of crossing cultural boundaries. Thus anthropologists have published innumerable discussions of the concept of person in various cultures. In South Asian studies, Marriott (1976) is often cited for his assertion that the Indian person is a “dividual” rather than an individual. Other South Asian researchers have also argued that the South Asian person, as conceptualized and as lived, is less discrete, less bounded, and more permeable by the environment than the European/North American individual. Person, however, is still taken as a baseline term, as transcultural currency, tradable anywhere on the globe. Will it turn out to be one of the counterfeit coins of colonial categories which Chakrabarty (1992:20) has suggested must be returned to its originators? In one study of the concept of person in India, Carter (1982) suggests that
vyakti is a term used for a person with a definable social status. His consultants might
comment, for instance, that a deceased infant was not yet a vyakti. Yet a deceased infant
clearly could have been a medical subject, a patient, a person from the standpoint of
medical anthropology. It is for reasons such as these that my attempt to identify Vd.
Sharma’s concept of person collapses in the doubt about comparable terms.

12. For additional critiques of positivism, see Fabian 1983; Haraway 1991; and

13. The use of the negative in this clause reflects the fact that Vd. Sharma is
mentally translating from Hindi where the negative would be used in such a construc-
tion. In English the same meaning requires the removal of the negative.

14. This should not be construed as unusual. Even those doctors interviewed who
were far more critical of biomedicine than Dr. Karnik considered their hospital experi-
ence an asset.

15. This particular correlation of illness categories is one that Vd. Sharma would
make as well. In general, however, Vd. Sharma is less likely to make use of such
correlations than Dr. Shukla.

16. It should not be inferred that recent ethnographies conceive of Ayurveda as a
unitary system of beliefs shared by practitioners and patients across South Asia. Careful
ethnographic work has been done both to acknowledge the diversity and fluidity of
Ayurveda and to distinguish classical, folk, and contemporary practitioners’ models.
See, for example, Nichter 1980; Nordstrom 1988; Obeyesekere 1976; and Zimmermann
1978.

17. One might be tempted to surmise that Dr. Shukla’s patients are more skeptical
of Ayurveda than the general populace because they are better educated. According to
those Ayurvedic doctors with whom I discussed the issue, however, urban Indians of
all classes, as well as many rural Indians, have similar conceptions about Ayurveda. If
anything, Dr. Shukla’s more educated patients seem to have more knowledge of
Ayurvedic principles than his less educated patients.

18. See Zimmermann 1992 for an interesting discussion of some of the effects of
the holistic movement on contemporary Ayurveda.

19. Arney and Bergen (1984) have argued that over the last two decades, biomedici-
cine is increasingly turning toward more systemic models of disease, which include
greater attention not only to the total somatic environment but to psychosocial factors.

20. See Wolffers 1989 for a related discussion of the range of Ayurvedic responses
to competition from biomedicine.

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