CHAPTER 10
CONCLUSION

We began our study of the two medical texts the Caraka Saṁhitā and the Suśruta Saṁhitā with the objective of adding a new dimension to the study of ancient Indian society. The canonical literature, the Epics, the law books, semi-canonical literature and Sanskrit plays have been conventionally used as sources for social history. On the other hand, scholarship on the medical works has focused on the roots of Āyurveda, the antiquity and development of the ancient science of healing, the fundamental principles, materia medica, medical ethics, etc., but there are few sociological studies on the treatises. Disease and healing can be situated in the social framework. As disease is no longer viewed only as a biological process but also as a social construct, the social and cultural aspects of illness and healing are extremely relevant.

This study has examined various aspects of disease and healing. We have first dealt with our primary sources and the problem of dating the texts owing to the multiple layers of interpolations, some of which we have attempted to identify. The pivot of the medical system is the physician; consequently the study has examined several aspects of the medical profession including specialisation, professional code of medical practice, interaction with society, educational training and individuals associated with the physician in the process of treatment in an auxiliary capacity. The medical concept of disease and its social implications have led us to examine the nature of treatment, societal perceptions, class and gender differences in therapeutics as well as the circumstances of the denial of treatment by medical practitioners. We have attempted to understand whether physicians hold the same notions of stratification and hierarchy as in the brahmanical texts, and how they dealt with issues of class, caste and gender.

Since prevention of disease is one of the concerns of Āyurveda, concepts of health and hygiene in relation to the environment as well as prophylactic measures have also been studied. In yet another chapter, the issues associated with the processing of medicinal formulations and preservation of drugs have been
investigated to understand the complexities involved in the process. The religious aspects of healing and how far they impacted therapeutics and the concept of rational medicine are another aspect of this study. Significantly, the discourses of both the medical compendia are rooted in the Brahmanism. Āyurveda is considered an upāṅga of the Atharvaveda. Adherence to formalistic elements of Brahmanism is evident throughout the Saṁhitās, particularly in the display of reverence for Vedic rites and observance of the Vedic rules. The final chapter has looked at various aspects of surgery, a specialised branch of Āyurveda, particularly, the perception of surgery among the surgeons and practitioners of internal medicine and the care of the surgical patient.

The medical texts have the potentiality of providing us with a different lens with which to view society, disease, healers and healing. It is for an alternative brahmanical perspective that we have selected the treatises of Caraka and Suśruta as our primary sources.

The study of medical scriptures has a long history going back to the age of the Vedas. The vaidya of the medical treatises was preceded by the bhiṣak of the Rgveda and the Atharvaveda who had knowledge of herbs and mastery over the recitation of charms and incantations. Gradual enhancement of knowledge required its systematization which is evident in the compendia of Caraka and Suśruta. The composition of the two Saṁhitās marks emergence of the two main specialised streams of Āyurveda, i.e., medicine (kāya-cikitsā) and surgery (śalyatantra). These are not the only specialised branches for the other subdivisions of this science offer ample scope of specialisation. The practice of referring cases to other streams is also evident as patients requiring surgery are advised by Caraka to approach the Dhānvantarīyas who are skilled who are skilled in various surgical procedures. At the same time, there are allusions to the undercurrents of rivalry between physicians and surgeons in their respective descriptions of the attributes of the royal physician by Caraka and Suśruta.

It is the medical Saṁhitās that for the first time elucidate who among the healers can rightfully claim to be a bhiṣak or a vaidya, and define the position of the physician in therapeutics. An excellent grasp of theory and extensive practical experience are the principal attributes of an ideal physician. He is distinguished by
many other qualities of which Caraka includes yukti or the ability to deduce logically from circumstances. Our study shows that physicians who are much denigrated in the brahmanical texts, claim a respectable position for themselves and their profession on the basis of their medical education which, according to them, ensures the status of dvijas (twice-born) for the medical practitioners.

One of the hallmarks of a true physician, as we have shown, is learning from a qualified preceptor. Medicine, like any other branch of knowledge, has a very well-established system of imparting knowledge and handing it down from generation to generation. Unlike many other systems of knowledge, it has two distinct branches – the theoretical and the practical. Anatomy has been given far greater emphasis in the surgical curriculum for which dissection of human corpses and experimental surgery on animal carcasses was essential. From the description of the eligibility criteria there appears a preference for young students in surgery unlike medicine which could be taken up at a later age as well.

This research has highlighted a significant aspect of medical education, i.e., its inclusive nature. Varṇa is not an important consideration as we have seen that apart from the upper three varṇas, śūdra students are accepted in the school of surgery. Caraka does not specifically include the śūdra student but states that Āyurveda can be studied by all. The medical authors take an enlightened view of learning considering that in many other aspects, such as the initiation of the student, suitable time of study, occasions for suspension of study, etc., more or less conform to the norms of Vedic learning. Our analysis shows a probable change in student-teacher relationship in the two treatises. In the time of Caraka, the student is expected to live in complete submission and render services to the preceptor but by the time of Suśruta the relationship had probably grown more contractual in nature.

The systematization of knowledge had its repercussions in many directions. The system of enlistment of practitioners which is not known to Caraka but had come into existence later as Suśruta mentions the necessity of taking permission of the authorities before one can commence his practice. Suśruta clearly refers to a system of registration of medical practitioners when we keep in mind that quacks and tricksters (kuvaidyas and taskars) have been strongly castigated for their lack
of knowledge and absence of medical ethics. These references point to the existence of other types of healers who posed some competition for the practitioners of the Āyurvedic schools.

It is in the Saṁhitās that we find an elucidation of the notions of disease and health as well as a more rational approach to disease aetiology on the basis of the physiological functioning of the body. This theoretical perspective is far cry from the Vedic conception of disease as the personification of some demoniacal beings or as the manifestation of the will of a supernatural power. Many factors are included in disease causation in the Saṁhitās: genetic make-up, improper antenatal care, dietary indiscretions, injudiciousness in the daily regimen, trauma, seasonal vagaries, emotional disturbances, contagion, malevolent beings, spells and black magic. It has been pointed out that though notion of malevolence and the infliction of wilful harm as causative factors persists in a certain clinical conditions like intermittent fever, some mental disorders and paediatric diseases, it may have been necessitated by a partial understanding of disease aetiology. These diseases are considered difficult to treat. However, even in these disorders, the manifestation of symptoms arises eventually from the imbalance of the doṣas though the physiology behind the disease is not exactly understood.

An interesting aspect of disease aetiology we have examined is its correlation with concept of karma. We observe that Caraka accepts the working of karma but does not consider it to be immutable. The immediate root cause of disease is the disturbance of the doṣas but the distant cause of its vitiation is identified as unrighteousness (adharma) or bad deeds of the past life (asatkarma pūrvakṛtaṁ). Both have their source in the violation of good judgement (prajñāparādha). For Suśruta it is not a crucial causative factor and only such diseases are termed ‘karmaja’ for which there is no known cause.

Popular perceptions regarding disease find mention in our treatises though they do not impact medical therapeutics which is determined by pathophysiology of the disease. This we shown in the context of a much dreaded disease like kuṣṭha (skin dermatoses) that is most commonly associated with evil deeds and is referred to as pāparoga. The medical authors consider kuṣṭha difficult to treat because of the vitiation of all the seven dhātus and acknowledge the contagious nature of the
disease. Yet this did not prevent physicians from attending to patients with manifestation of severe physical deformities whether it is maggot infestation or sloughing of the extremities of the body. We also have evidence that the layman’s notions of clinical conditions differed from that of medical science, and in some instances, they are repudiated in the texts. The perception that in false pregnancy, the foetus is removed by some evil spirit that moves about at night and feeds on body of the foetus is countered by Caraka with medical arguments.

Apart from skin disorders, patients of certain other clinical conditions such as the mental disorders and (possibly) epilepsy encountered social stigma and discrimination. Our research indicates that the treatment procedure, especially in mental disorders, often involved isolation and brutalization of the patient. However, the attitude of our Saṁhitās towards disease is not prejudicial and there is no upfront expression of disapproval of any particular clinical condition. Physicians are expected to attend to any clinical situation without being judgmental.

The objective of therapeutics in Āyurveda is essentially the restoration of the equilibrium of the doṣas, and the process is initiated after consideration of several factors, such as the nature of the disease, habits of the individual, his physique, his digestive capacity, the appropriateness of time (kāla) and the locale (deśa). The latter two factors are taken into consideration for the living being does not have existence in isolation from his environment. Understanding the susceptibility of the human physiology to the cyclical changes of the environmental conditions is not only important for the treatment of physiological imbalance but is also central to the prevention of disease. Epidemics are associated with deviations of the normal characteristics of the air, water and the locale in the Caraka Saṁhitā.

Scholars of ancient Indian medicine have looked at doctor-patient relationship in the context of medical ethics delineated in the medical texts in which questions of class or gender have not been examined in depth. As the physician operates within in a stratified milieu, the issue of hierarchy is likely to impact the human factors involved in therapeutics. We have noticed that appropriate therapeutics in certain clinical conditions is conditioned by the issues
of class and gender as also by the personality of the patient. The perception of financial well-being as one of the desirable attributes of the patient and the inability to gather the necessary medication as a possible cause of failure of treatment is an indicator of the weight attached to the monetary status of the patient. The poor, the dependant and the orphan are three categories among others of patients who should be treated at the physician’s expense according to Suśruta.

Preferential treatment is evident for kings, the rich, infants, the aged, the timid, the weak, women and those of delicate constitution. The ability to withstand pain is an important factor in determining the nature of therapeutics. We have shown that treatment process was sensitive to the condition of the patient, the state of the disease as well as to the financial status of the patient. Rejuvenation (rasāyana) and aphrodisiac (vājikaraṇa) therapies were formulated for the affluent. These anti-aging rejuvenating formulations were prized classified knowledge for they are safeguarded against their revelation to undesirable persons like non-dvijātis and women. Medicinal recipes formulated exclusively for the royalty, the well-to-do or other persons requiring specialised treatments are frequently mentioned in our texts. That therapeutics was structured keeping in consideration the patient’s social situation is best exemplified by the treatment of prameha (diabetes with urinary disorders). Suśruta prescribes disparate dietary and physical exertion regimen for the royalty, the poor, the brāhmaṇa and the cultivator.

The discussion of perception of gender in the medical world and the treatment of female diseases has thrown up some interesting issues. We are, of course, handicapped by the silence of women’s voices in the texts. It has been noticed anatomically the female body is practically absent in the Caraka Saṁhitā but the Suśruta Saṁhitā has devoted some attention to the dissimilarities of male and female anatomies. The absence of a branch of medicine devoted to female diseases points to the marginalisation of women in ancient Indian medicine. The concern with the female body of the ancient Indian medical authors is primarily from the perspective of procreation. Pregnancy and childbirth are the principal areas of gynaecological concern in the treatises. The twenty types of yonivyāpad or gynaecological disorders that have been incorporated in the texts are again
concerned with the specific purpose of removing impediments to conception. In the two compendia, there is not a single chapter devoted to gynaecological diseases. There is also overwhelming concern with the procreation a male child of excellent qualities, and it the post-natal care of the mother of a male child that the authors are concerned with.

Discrimination towards women comes forth in the compendia in all other contexts where the patient is invariably a male and so is the physician. The medical discourse is mainly centered on the male body. The rules of personal hygiene for maintenance of sound health and prevention of diseases are essentially prescribed for men though many of them would be applicable to women as well. The directives on apparel and physical relations have a purely male orientation. Other than as midwives and wet-nurses, the marginalization of women’s role in therapeutics is all too evident. Women make their presence felt during the management of labour and child delivery, postpartum and neonatal care in which female attendants are acknowledged to be skilful.

We may surmise that the male practitioners attended to a good number of women for the physicians’ etiquette for female patients is clearly laid out by both Caraka and Suśruta. Physicians are advised to take precautions in administration of drugs and therapies to female patients who are generally considered difficult to treat possibly in view of their shyness and hesitance to reveal all symptoms.

The physician could not function without the support of his assistants (paricaral/paricāraka) who attend to the myriad duties from gathering of drugs and processing of medicines to attending to the needs of the physician/surgeon during the course of the procedure and period of recuperation. There is also the possibility of these attendants being organized into a hierarchy according to their responsibilities. The requisite abilities of the attendants vary according to the needs of the physician: medical attendants with knowledge of looking after the sick are preferred while the surgical attendants are expected to be affectionate, strong and indefatigable. The patient probably had his own attendants for taking care of post-operative nursing. Suśruta has emphasised the role of friends and family members in post-operative care, especially those who are great conversationalists and would keep the patient’s mind diverted from pain and relieve his anxiety.
The management of drugs itself, we may surmise, would have required a large number of assistants given the large number of substances of vegetable, animal and mineral origin that are mentioned in the two treatises. The complex formulations are labour intensive and requiring substantial monetary investment which raises questions about drug management and the trade network through which they were procured. We have demonstrated that many of the ingredients mentioned are habitat-specific and some ingredients were of foreign origin. It is a possibility that in view of the cost-factor and difficulties in obtaining drugs, physicians are advised to refrain from giving medication to the incurable patient. The issue of drug network opens up new vista of research within the sub-continent and beyond.

One of the concerns of Āyurveda is prevention of disease. It in this context we have looked at the conceptions of cleanliness and hygiene in the texts. Cleanliness has been associated with purity and the absence of disease. A direct correlation between contamination and disease is noticed in the texts. Absence of hygiene is admitted as a causative factor of disease; it is the cause of afflictions of malevolent agents, known as rākṣasas, bhūtas and grahas. These beings can be said to represent a supernatural approach to the concept of disease and infection. Management of personal hygiene, cleanliness of the kitchen and food hygiene are described as prophylactic measures.

The concept of hygiene, however, is not restricted to the physique for the concern of ancient Indian medical science is not confined to physical health alone. It is all-encompassing with consideration of psychological and ethical issues as well. Physical health has a close correlation with mental as well as with social health. Hence, we find recommendations for moulding an individual’s ethical behaviour by controlling the immoral urges of the mind. The principles of sadvṛtta have been formulated to help to maintain health and control the sense faculties as part of preventive medicine.

For developing control of the sense faculties (indriyāṇi) the authors enjoin ethical behaviour as well as ritualistic and magical practices. The incorporation of religious beliefs and rites as well as magical practices in therapeutics, recognised as daivavyāpaśraya bheṣaja, raises questions about its raison d’être. We notice
that the magico-religious approach as a therapeutic measure is particularly advised in the context of those diseases that are admittedly difficult to cure. They include fever, consumption, epilepsy, poisoning, psychic and paediatric disorders. Adoption of this approach is not uniformly evident in the Satāhitās. The Śālākya-tantra section is remarkably devoid of ritualistic aspects while the treatment of paediatric disorders is wholly dependent on it. In fact the tenor of the Kaumārabhya section of the Suśruta Satāhitā is significantly different from rational principles of Śalya-tantra or Śālākya-tantra. Paediatric diseases were perhaps less understood than other diseases.

The perception of a direct correlation between righteousness and well-being, both physical and psychological, appears well rooted in ancient medical theory. Ātreya’s exposition on the gradual appearance of vices in humans in the four mythic ages with the passage of time is associated with the growth of unvirtuous behaviour and decline of longevity. Unethical behaviour caused by the immoral urges of the mind is believed to affect the body and the mind in the form of disease.

Ethical behaviour and ritual practices, therefore, are believed to be prophylactic in nature. The occurrence of epidemics, for instance, is held to be preventable by following such codes of conduct. Therefore, one may argue the interpretation of disease aetiology and the importance given to the mind and the soul in medical theory occasioned the concept of magico-religious practices as a form of therapeutics in Āyurveda. It is interesting to note in this context that the nāstikas (non-believers in the authority of the Vedas) are severely criticised for their beliefs as the worst of the sinful. The intrusion of non-rational elements may be attributed to inadequacies of the medical theory itself to explain particular clinical symptoms or of the curative process itself.

Despite the presence of magico-religious elements, the position of medicine in the Satāhitās is not overwhelmed by ritualism. In fact, theurgic rituals supplement clinical therapies. There are subtle assertions of the effectiveness of medicine over charms and spells. We have shown how Suśruta, hereby, in an understated way, sets forth the case for the reliability of medicine in relation to sacred utterances in the treatment of poisoning.
We have also studied at the association of the deities mentioned in the treatises with healing. It has been noticed that the healing role of female divinities is completely absent; rather, they are conspicuous by their negative role as causative of diseases. Second, the twin deities, the Aśvins who are so highly euologised by Caraka, find little mention in Suśruta. The latter holds Dhanvantari in high esteem.

The brahmanical orientation of the texts did not, however, bring about conformation of the physicians with the norms of the stratified society. We notice that in many respects the practices advocated are antithetical to brahmanical ideology. The inclusive nature of medical education, the dietary prescriptions (especially in the treatment of consumption), handling of faunal drugs that are essentially polluting to the orthodoxy are some these aspects that we have highlighted in our thesis. On the issue of the social position of physicians the authors of the Sāṁhitās hold a divergent view from that of the brahmanical doctrine. The denigration of the medical practitioners in later Vedic corpus and the law books and the pronouncement of the divine physicians as impure do not find mention in the treaties. The authors hold the medical profession as highly respectable which brings fame, virtue, wealth and pleasure. Practitioners of this science are described as saviours of life. While Manu designates the art of healing as an occupation for the base-born and specifically assigns it to the ambaśṭhas, Caraka asserts that medical education ensures the position of dvija. Significantly, the term ambaśṭha in the sense of a physician does not occur in our treatises. We may read this as an attempt to refute the brahmanical position and establish the honour of the medical profession.

Our study shows that the normative brahmanical texts are not reflective of the true position of medical practitioners. Supportive evidence from epigraphs throws a completely different light on the social status of the vaidyas, some of whom were appointed to high positions and received honour and respect from kings. However, the position of the surgeon vis-à-vis the physician underwent gradual deterioration. Unfortunately, evidence on surgeons in inscriptions is very meager but inscriptive evidence shows their position was inferior to that of the physician. Possibly the handling of corpses, blood, pus and other polluting matter was responsible for their social stigmatization. As we have shown, surgeons had to
work with blacksmiths, hunters, potters, leech-gatherers and others lower down in the social hierarchy which may have been a contributory factor.

The question we return to is whether the perspective of the medical fraternity we have in the medical texts is different from that of the brahmanical orthodoxy. The acute observations regarding the proneness of some sections of society to disease and references to clinical difficulties faced by the physicians during therapeutics are drawn from their experiences. It is evident that their interactions cut across different strata and denominations of patients. There are references to the various categories: those who recite the Vedas (śrotriyas), kings, royal servants, ladies, infants, the aged, the timid, royal servants, rogues, weak patients, quacks pretending to be doctors or one who pretends to possess a knowledge of science of medicine (vaidyavidagdha), those who conceal diseases, the poor, misers, short-tempered persons lacking self-control, orphans, courtesans and traders.

We have looked at the issue of denial of treatment. Incurability of disease or imminence of death are the primary reasons in most cases to reject treatment but our study indicates that sometimes palliative medications are prescribed for clinical conditions otherwise termed incurable. The physician may deny medical intervention on several other grounds ranging from the person’s temperament traits to his psychological disposition, social and religious attitudes as well as his social standing. Absence of faith in the physician or the treatment is cited as a factor for not taking up a patient. Those involved in sinful acts or accused of crimes are also denied treatment. Suśruta mentions two professional groups in particular in this category: the hunter and the fowler. The restriction on hunters and fowlers appears strange for drugs of animal origin could be collected with their assistance. These groups may have had their own healing systems. However, no particular caste is mentioned as unworthy of therapeutics. Thus, the physician is entitled to exercise his discretion in taking up a case.

The disposition of the physician towards his patients is expected to be friendly, compassionate and caring on one the hand, and protective and caring as a father on the other. Friendliness to all creatures, mercifulness to the poor and solace to the fearful are some of the aspects of ethical behaviour that is enjoined
upon every individual. Even though a physician may not be permitted to treat such patients who are charged with treason or are fallen otherwise, he should have inner sympathetic attitude towards them.

The objective of Āyurveda is to ensure good health and happiness of men in this world and beyond. Both our treatises begin their discourses with the premise of relieving people of their sufferings arising from different types of diseases. The objective of acquiring the knowledge of longevity is the well-being of all creatures (prajāhitam). The ancient Indian physicians reveal a relatively more open-minded perception of society. Thus, one may construe that the origin of the practice of this medical science derives from its principle of providing succour to all persons irrespective of social rank or gender, and the practitioner is idealized as the genuine embodiment of this ideal.