Chapter 1
The Intersecting Triad: Kalari, Vishavaidyam and Ayurveda

This chapter contextualizes the research and research objects by laying out a literature review of the existing scholarship. It also discusses a few key terms used in the thesis. The study does not differentiate nattuvaidyam as folk medicine or as a marginalized tradition among medical practices, as distinct from institutionalized modern ayurveda. In other words, ayurveda is not seen as a pre-given, codified and systematized medical practice that existed all over India prior to the colonial period. The study views the making of ayurveda as a classical tradition (Basham 1976, 18-43) that occurred through a series of processes. They include interactions, incorporations and simultaneous erasure of heterogeneous healing practices within the larger discursive field of biomedicine, and modern education. From the very beginning, the work discerns the idea of a centre-periphery relationship among practices, as this perspective functions as the foundational premise of the larger scholarship (Panikkar 1995, Leslie 1993) on indigenous healing practices.

Though there is teaching, learning and transfer of skills in both modern education and indigenous knowledge practices, there seem to be some crucial differences in the ways in which these systems and practices negotiate with each other and develop their perspectives towards life, health and death. How is knowledge systems derived, divided, differentiated and systematised? How do they attain

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1 For this perspective see the works of Panikkar 1995, Hymavathi 1993, Kutumbiah 1962, Basham 1976.
2 Biomedicine here is modern medicine introduced in India in the nineteenth century and supported by the state as the prime medical practice of India. It is called as allopathic medicine or ‘English medicine’ by the people. The Greek term ‘allo’ means ‘the other.’

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positions of relative privilege? These questions are central to unravelling the process that led to the segregation of practice, knowledge and skill in many indigenous systems. In this thesis I do not separate ‘practice’ from ‘knowledge’ but see it as inclusive of knowledge. The concept ‘knowledge’ that gained prominence in the late eighteenth century did not bear any single definition. Plato’s definition of knowledge as “justified true belief” bears three conditions for anything to become knowledge; justification, truth and belief. Knowledge is also defined as “a product of social material and intellectual activity of people; an ideal reproduction in sign form of objective properties and connections in the world, of the natural and human” (Frolov 1967, 212). In the Penguin Dictionary of Philosophy, knowledge is not the same as belief or opinion (Mautner 1997, 328). From the nineteenth century onwards, the buzzword knowledge has become equivalent to modern education because education is meant for disseminating modern, western knowledge. (Kumar 2005, Seth 2007). By this time, in order to access knowledge, a subject has to undergo certain refashioning, and knowledges position and construct knowers in different ways (Seth 2007). This is not so in the case of a practice or rather ways of knowing where knowledge, knowing and the knower/subject are intermingled. I would use both these terms - knowledge and practice, interchangeably to denote ways of knowing in vaidyam. However, the word ‘practice’ is not sufficient enough to represent vaidyam as practice indicates the application or acting out of something. In Malayalam the equivalent is prayogam. In the context of vaidyam, prayogam also denotes ‘composition of medicines’ apart from action, practice, usage, application etc.

This thesis will look closely at the transformations in two indigenous healing practices of Keralam, namely, kalari and vishavaidyam, in their co-existence and
interaction with modern education, and the idea of knowledge that evolved in the course of time in relation with them. In order to write about the emerging dominance of the historical, as Prathama Banerjee argues, it is essential to understand the discursive and material processes through which the non-historical is also constituted. She suggests that in the process of writing history, there are ways in which the primitive, the indigenous and the other are situated. In fact this production of the historical leads to the construction of two subjectivities, the historical and the anthropological (Banerjee 2006, 1-39). In the same vein, it is suggested here that in order to understand the privileging of certain knowledge systems such as modern education and ayurveda over other indigenous healing practices, one has to look at this process from the location of the latter that has been positioned in a particular way as marginalised practices in the history of the production of knowledge. Then it is possible to see the discursive field through which the former is validated as significant sites of knowledge. This process not only involves configuration of certain norms that validate knowledge but also function as the necessary condition through which the knowledge can be accessed.

The present research aims to lay out an understanding of the processes in making modern education the axis of knowledge production and the simultaneous erasure of other knowledge practices through an observation of selected nattuvaidyam texts and practices and an analysis of a few internal concepts within it. Modern education, an important component of ‘modernity,’ acts as an influential system

3 Modernity is the rise of a number of key features in the social organization of the seventeenth century Europe that extended their influence throughout the world. This includes the emergence of discourse on reason and rationality with the concomitant growth of science, the spread of literacy, industrial production with capital investments, the idea of increasing social mobility, the consolidation of nation-state, the secularization of society and the new texture of selfhood based on the liberal concepts of freedom, autonomy and individuality (Calhoun 2002, Ashcroft et.
working through a series of processes. These include incorporating different and
diverse knowledge systems into a centralised form of knowledge production and
applying its norms to other systems, fixing conditions for what qualifies as
knowledge and also introducing stipulations to access that knowledge. This
assimilation and erasure take place not through coercion, but through methods of
incorporation, standardisation, categorisation and simultaneous differentiation
(Cohn 1996). It need not amount to the total extinction of certain practices, but
can result in significant transformations in their form and essence. This research
seeks to arrive at a closer understanding of these processes in relation to the
transformations in two indigenous practices, *kalari* and *vishavaidyam*, their
norms and ethics, the play of power within them and their negotiation with other
similar practices.

**What constitutes the indigenous?**

The term indigenous is used in this work, to denote those which have sustained
themselves in a limited or enlarged geographical area within encouraging or
hostile situations for centuries, irrespective of their origin. These practices have
been adaptive and have attained certain attributes unique to the region where they
are located. The idea of indigenous in this thesis is different from the given
dictionary meaning, which emphasizes and restricts the practice as autochthonic.4

This study prefers the term ‘indigenous’ to ‘traditional’, even when the term
indigenous is not sufficient to capture the internal dynamics of a practice that is

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4 Merriam-Webster Online Dictionary defines the ‘indigenous’ as “having originated in and being
produced, growing, living or occurring naturally in a particular region or environment.” (See [http://www.merriam-webster.com/dictionary/indigenous](http://www.merriam-webster.com/dictionary/indigenous) accessed on 05.3.2015). Oxford Dictionary defines
indigenous as “originating or occurring naturally in a particular region or environment” and “native.” See [http://www.oxforddictionaries.com/definition/english/indigenous](http://www.oxforddictionaries.com/definition/english/indigenous) accessed on 05.3.2015).
sustained in a region. The idea of ‘tradition’ changes tremendously during the period of colonial intervention and with the inauguration of the enlightenment era. Its meaning is entangled with and constituted by modernity (Visvanathan 2007). What is traditional is always determined by the measure of what is not modern and not enough to be incorporated into the capitalist production. The common way of understanding any indigenous practice is to place (or rather push) them into the realm of tradition, assuming tradition as something situated in the past, negotiating with the present through its ‘pastness’. Tradition, with its attributed baggage of pastness, innocence, irrationality and heritage, is posited as the ‘other’ of the ‘modern’. Traditional practices are situated against modern western knowledge, inaugurated with the arrival of new scientific consciousness (Visvanathan 2007, 182-217). At times, tradition also serves as a symbolic capital of communities, castes or regions depending upon the cultural market value and visibility. Another approach in this area is that of the ‘inventing tradition’ model involving a process of formalization and institutionalization of practices with reference to its past and its repetitive nature (Hobsbawm & Ranger 1983). All these perspectives applied certain norms and logic in ways of thought which, in fact, follow different forms of logic (Glenn 2000). Cultural forms are identified and classified as tradition within the historical relationship between the colonizer and the colonized that devalue and restructure the very tradition (Dirks 2002). Scholars find tradition and modernity, not only as self-critical sites, but as a

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5 His Excellency’s reply to the address presented at the opening of the Ayurvedic Dispensary at Cheruthurthy, Keralam, states: “The essential part of any institution - a research institute well equipped and well managed - should be on modern lines. By this means alone can the accumulated traditions of the past be tested and freed from all the dross which inevitably gathers round a system which looks too exclusively to the past.” GO No.475-476 dated 19.11.1917, Local and Muncipality Department (Medical), The Indigenous Medicine, Tamil Nadu State Archives (TSA).

6 Kalari became the martial art of a geographical location named Keralam (Vijayakumar 2000), Ayurveda became the indigenous healing practice of India (Basham 1976) and Siddha became the unique healing practice of Tamil Nadu by the mid-twentieth century (Weiss 2009).
complicity of opposites (Visvanathan 2007, 183). While sharing some commonalities as well as contrasting perspectives, traditional practices share and borrow many elements from other practices which have different logic. This work will retain the Malayalam term ‘nattuvaidyam’ for ‘indigenous medicine’ throughout the chapters and use both the terms alternatively.

The term ‘knowledge systems’ is used to include a wide range of systems and practices that generate and transmit knowledge and skill, responding to the instrumental and institutional needs of various periods. The idea of a system that is inherent in a set of interacting or interdependent components forming an integrated whole (Parsons 1951) was applied to indigenous practices from the early twentieth century as they also have shared norms and values and have a functional relationship. The origin of the concept of indigenous knowledge systems (IKS) can be traced to the debates over intellectual property rights among the Australian and Canadian tribes (Lewinski 2008). There IKS is posited against the dominant western knowledge system. When we look at the Indian scenario, such a conceptualization is inappropriate because here a dominant and institutionalized practice such as ayurveda is an IKS and a tribal medicinal practice also is IKS. When I use the term IKS, I intend to attribute neither a collective marginality nor an assumed collectivity to different IKS. Though knowledge is a modern concept with connotations of objectivity and distanciation, by using the term IKS, I would like to associate it with the known term ‘indigenous practices’ and to qualify it further as inclusive of knowledge, skill and labour.

This work does not deal with adivasi vaidyam (tribal medicine as it is known popularly and in official documents) even though it is also one of the indigenous
healing traditions. *Adivasi vaidyam* and *nattuvaydiam* are distinct in many ways. The medicines used in both practices are different though both use herbs in their treatment. *Nattuvaidyam* is spread all over Keralam and in most of South India (under different names) and is largely based on the principle of bodily humours or *tridosha* principle. *Nattuvaidyam* is ayurveda, even though in the twentieth century, the institutionalized, modernized and standardized ayurveda separates itself as a distinct entity independent of *nattuvaidyam*. *Adivasi vaidyam* is never known as ayurveda despite its herb-based treatment. In other words, ayurveda differentiates itself from *adivasi vaidyam* in its practice. The practice is popular among the *adivasi* community. People living in other locations utilize this treatment by going and meeting the practitioners in their settlements. The distinction is not merely of a spatial separation but also of cultural difference between the practitioners.

**Methodology**

Methodological questions shape the nature of data gathered and the way the researcher utilizes and situates them in the field of writing. It also reflects the subject position of the researcher within the data gathered, the people interviewed, and the theories put into use to interpret these different registers and the success in combining the three which often move in divergent directions. The

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7 There are three humours in the body, *vata, pitha, kapha* (which is often wrongly translated as wind, bile and phlegm. Valliathan translated these three humours as wind, fire and water). They are aligned with opposite qualities such as hot-cold, wet-dry etc. and the equilibrium of these humors maintained health. (Valliathan 2003). Wind, fire and water do not indicate the very nature of these phenomena. Instead the functions of these three humours are on par with the nature of wind, fire and water. Wind helps all kinds of internal and external movements, fire help digestion (*pajanam* and *deepanam*) and water nourishes the body and activates the mobility of wind (Murti 1948, 88-91). The basic tenets of *nattuvaidyam* are more or less based on the same concepts of humours which relied on the fundamental macro and microcosmic connections between human beings and the cosmos in which they lived. But by the mid twentieth century, practices such as *kalar* that did not follow the humoural perspective, has also begun to introduce it as their principle.
dissonance between theories and the field of research can be seen, spread throughout the work. The conceptual tools also provide a firm support in holding the materials together without erasing their diversities and contrasting character.

This study looked into a variety of sources in writing the thesis. They include government reports, the correspondence and proceedings in continuation of the reports, government orders of the earlier princely states of Travancore and Cochin as well as that of Malabar/Madras Presidency, Proceedings of the Committee on Indian System of Medicines, the first Committee Report on Indigenous Systems of Medicine, etc. Vernacular sources such as texts used for learning *vishavaidyam* and *nattuvaidyam* are also used as sources. A variety of magazines on *vaidyam* such as *Sukhashami* (1922), *Arogyavilasam* (1926), Ayurvedic Gazette (1932-33), *Ayurvededachandrika* (1947), *Vaidyabharatham* (1971-72), *Physician Ayurveda Masika* (1978), *Ayurvedaratnam* (1978), etc. published from the early twentieth century have been looked into. A special mention is required on *Dhanwantari*, a *vaidya* magazine published from Keralam for a span of 23 years from 1903 onwards that initiated significant discussions on *nattuvaidyam*. Autobiographies and biographies of vaidyas; ballads used in *kalari* etc. have also been used, apart from archival materials. Interviews of practitioners in *vishavaidyam*, *kalari* and *ayurveda*, were utilized to supplement the textual materials.\(^8\) The field work comprised of extensive interviews, attending workshops and seminars conducted by the practitioners and protagonists and observing practices. The data gathered can be classified as: 1) historical record of

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\(^8\) In the contemporary period, practitioners who acquired degrees from ayurveda educational institutions see themselves as pure ayurveda doctors, whereas practitioners of *kalari* and *vishavaidyam* see themselves as following ayurveda but specialized in their own fields. (Interviews with *kalari*, *vishavaidyam* and ayurveda practitioners in different months from 2010 to 2015)
In the attempt to understand the epistemological premise of nattuvaidyam, the study invokes a few questions. In vishavaidyam, the modes of classification (of snakes, other animals, plants and their poison, medicines administered, etc.) are different from the methods of modern scientific classification. Yet they follow a logic and pattern of broad classification. Both kalari and vishavaidyam (or nattuvaidyam in general) do not use written texts as everyday reference books for practice. However, the practitioners memorize verse after verse through reiteration during the course of learning and use them as mnemonic devices at the time of practice. In kalari, the memorization and reiteration happens at the level of body and in bodily actions, through everyday practice. The vaythari or verbal codes have only a secondary role in practice. No texts are used in kalari as a ready-reckoner or as a reference book, either for doing kalarippayattu or for treating muscle injuries and bone fractures. But, after mid-twentieth century, a proliferation of texts can be seen, written by practitioners on marmavaidyam and published through both well-known and less-known publishers.  

9 Kalarippayattu and the related healing traditions still do the learning through everyday practice and not by referring to any texts, especially written texts. In vishavaidyam, the

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9 See Rajeev Gurukkal 2002, Kalariyuzhichilum Marmachikitsayum; Ebenezer 2009, Marmachikitsa; G Asan 2010, Marmasastravum Marmachikitsayum.
reiterated and memorized verses in oral learning act as a code for treating the person affected by poison. The *vaidya* may refer to a text in case of doubt, but generally he refers to his memory to recall the series of medicines required for treating each case. A variety of medicines are prescribed in the texts for each and every disease and each case of poisoning. Forgetting one compound of medicine is not at all an issue, as the *vaidya* can easily recall another group of medicines. In contrast, in the modern ayurvedic educational institutions, the learning takes place on the basis of texts and thereafter in practical classes at hospitals. All this leads to the question of locating a different outlook and congruence among the text, its content and the author in the different contexts of indigenous practices and modern ayurveda practices. How does one approach practices which have a set of norms and codes in oral textual form? This is a question that my study encountered throughout the course of the research and one which has not yet been resolved completely. The challenge was to situate indigenous practices that followed a set of techniques of learning and had a different approach to the body, within their own internal logic and strategies.

*Kalari* and *vishavaidyam*, two distinct knowledge practices, have been juxtaposed here with a view to emphasise the need for understanding the varied, specific processes of transformation they have undergone over the years. One is ‘successful and organised’ if we posit a linear way of understanding progress, and the other one is not ‘successful and organised’ but still has not become extinct. The transformation of the practices as well as their negotiations with the state and other practices in the course of their survival strategy is studied in the light of the increasing influence of modern education. ‘Education’ here refers to ‘modern’ educational practices that proliferated from the nineteenth century onwards.
through various formal and informal systems. These included formal schools, colleges and universities that imparted education to the students who enrolled in these institutions as well as civil society systems such as the film societies, the library movement, the literacy movement and various conscientisation programmes of non-governmental organisations etc. The idea of knowledge in many a practice is treated as embodied and experiential by rationalizing pure knowledge as disembodied and objective.

In this context, how does education try to assimilate/erase and integrate/disintegrate other knowledge practices which have specific characteristics and different ethics in terms of its interaction with the world and with itself? How do other knowledge practices negotiate within themselves and with the development-oriented world? Does modern education reshape our understanding of other diverse systems of practices? In a similar vein, does an awareness of knowledge in indigenous practices redesign one’s relation with modern education? These are some questions that the thesis attempts to address in the following chapters while elaborating some of the specific debates between the institutions of the state and the vaidyas.

The attempt here is not to compare and contrast the indigenous knowledge practices with modern education or medicine. The emphasis is to understand their different modes of operation as well as their relation to life and health. The thesis moves away from a comparative study framework, as such a framework tends to posit certain practices or certain aspects within the practices as superior to certain others. Instead, it tries to put forward the changes that happened within a chain of things we named ‘development’ or ‘industrious and scientific revolution’ that leads to a change of attitude towards life and health. In other words, the
transformations within nattuvaidyam in general and kalari and vishavaidyam in particular render visible the ways through which these practices negotiate with the new ideas of progress.

The study does not approach indigenous knowledge practices as self-sustained, non-hierarchical and homogenous practices. It probes the play of power within them as well as in their negotiation with the dominant and state-patronised system of education and similar practices, since “education played an authentic role in the process of anthropologising, critiquing and traditionalising indigenous practices” (Sujatha and Abraham 2009, 35-43). The content-wise and form-wise divisions between textual knowledge and non-textual knowledge, the conceptualisation of spatial and temporal divides between the ‘modern’ and the ‘traditional,’ the secular and the religious and the material and the spiritual indicate some of the processes through which certain practices acquired a privileged position over other indigenous practices.

The study follows a non-linear approach for locating certain moments or vantage points from the late eighteenth century to the contemporary. An investigation into the past will show the ways in which the contemporary is produced, by making interconnections and dissociations with the historical and the ‘non-historical’.

The study is limited to the spatial location of Keralam and the transformations within kalari and vishavaidyam specifically, and nattuvaidyam vis-à-vis ayurveda in general. Nevertheless, it enables a framework to situate ayurveda, the present dominant indigenous medical practice, all over India. The changes that took place within nattuvaidyam pinpoint the earlier association of ayurveda with it and the present dissociation of an institutionalized and modernized ayurveda as a unique indigenous healing practice of India.
Beyond classification

In the context of this research, the two indigenous practices that I look into can be approached as healing traditions or medical practices. But they spill over from the framework of this classification as they include more than healing traditions. The practices address a wide range of issues that fall within an area that cannot be separated as rational and irrational or scientific and non-scientific. Prescribing any medicine for the cure of a disease is invariably a suggestion to regulate the dietary regimen, reinstate equilibrium of the body and a change in the life pattern. Thus, these practices invoke a reordering of mental and bodily activities, implied in a ‘care of the self’.10 Diagnosing a disease and prescribing medicine for it constitutes a procedure that considers not only the specific bodily dispositions, but also the conditions of the humours in order to give instructions for re-ordering the routines of the patient. Each practice can be seen as a code of conduct that leads to another code of conduct or another set of practices. The chikitsa or treatment also considers other codes of practices like jyothisham (astrology) or manthram (magical incantation), and seemingly enfold an entirely different realm of philosophical schools.11 The boundaries of different practices overlap in such a way that one invariably leads to the other.

10 Care of the self demands an attention of self on self. It is an ethical mode of being in the world and a necessary condition to practice freedom properly. Care of the self includes “to know oneself, to improve one’s self, to surpass one’s self, to master the appetite that risk engulfing you”, says Foucault. One cannot care for self without having a knowledge of self, as well as knowledge of a number of rules of conduct or principles which function as both regulations and truths or logos to control the unethical actions. (Foucault 1987, 112-131).

11 Many of the indigenous healing practices in India are closely linked to the philosophical schools of Samkya, Nyaya and Vaisheshika (Varier 1980, 65; Pathi 1944,1-5). Most of the practitioners of early twentieth century were well known poets or script writers. Sree Narayana Guru and Chattampi Swamikal were known for their philosophical teachings rather than for their efficiency in healing. When they treated and cured people this was seen as miracles done by the spiritual leaders (Viswambharan 1980). These two and other physicians like Kaikulangara Rama Varier, Kuttykrishna Menon, P.S.Varier and Raghavan Thirumulppad were poets, writers and philosophers.
Kalari and vishavaidyam are the two practices selected for the study. They are distinct practices that prevail in a certain region of South India that came to be named as Keralam. These practices support the maintenance of health, vitality and well being of the people. Through a study of these two practices, I specify the general nature of nattuvaidyam vis-à-vis ayurveda and the transformations it had undergone from the nineteenth century onwards. The practices also produced a number of vernacular texts that gave prescriptive and descriptive narratives about the treatment. Vernacular languages have always been placed beneath the ‘main’ languages, English and Sanskrit. The very idea of the vernacular is produced within the larger discourse of hegemonic languages.

Kalari consists of bodily exercises that are categorized and reduced as martial art in the early twentieth century. Forms of healing such as bone setting and vital spot massaging (marma/varma chikitsa) were integral parts of kalari. In the medieval period, reading and writing or, rather, education, was also an activity the kalaris were involved in (Ganesh 1997). Kalarippayattu was seen as a dispute redressal mechanism of the kings as well as that of other people who could financially afford the practitioners (Vijayakumar 2000). As mentioned above, kalari constitutes a series of practices and overlaps with areas of indigenous education, sports and medicine, if we place them in the modern classificatory system of disciplines. In the contemporary, many of the kalari practitioners prefer to differentiate their skills in such a way that they either train kalarippayattu or retain the healing part of bone setting and marma chikitsa. In Tamil Nadu, the neighbouring state of Keralam, a similar kind of practice existed,

12 Schools were also known as ezhuthu kalaris (centres to learn the art of writing) though they did not provide training in kalarippayattu and related forms of healings. (See Menon K.P 1986, Vol IV).
known as adimurai or varmakalai. Adimurai is the Tamil term for kalarippayattu and varmakalai literally means art of marma or vital spots (Zarrilli 1998). Many practitioners of these traditions in the southern part of Keralam are Siddha practitioners too. Kalari is closely related to Siddhavaidyam, since both utilize the basic tenets of vital spot massaging and pulse reading. The practice of kalari was not seen as a healing tradition at all, even though its medicines and methods of treatment often overlapped with that of ayurveda. Kalari is often termed as sports medicine despite people largely depending on this healing system for bone injuries and muscle injuries.

Indigenous toxicology or vishavaidyam is a unique practice pertaining to south India and the area geographically bounded in 1956 as Aikya (united) Keralam. Though vishavaidyam is seen as agadatantra, one of the eight specialized branches in ayurveda, it has its own unique methods of treatment and medicines not seen in the classical texts of ayurveda (Varier 1980). It had been an important specialized and unique medical practice of a particular region for quite some time. A number of texts on vishavaidyam in Sanskrit, Tamil, Malayalam and Arabi-Malayalam also represent the prescriptive and descriptive textual

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13 Siddha is one of the codified indigenous medical practices of south India. The textual corpus of siddha is mainly in Tamil. The siddha philosophy was initially critical of idol worship and temple systems. Later some siddhas merged with Saiva bhakti tradition. As in vishavaidyam, siddhavaidyam also used mantram and tantram in its practice along with medicines. In north India, the nathsiddhas constituted a heterodox group more interested in iatrochemistry, a branch of chemistry and medicine rooted in alchemy (White 1996, 1-14).

14 Bone setting was never part of ayurveda. Even today, none of the ayurveda clinics provide treatment for bone-fractures. They provide post-operative care through oil massage and physiotherapy. But kalarichikitsa centres treat bone-fractures and provide vital spot body massage.

15 The region was territorialized and named as the state of Keralam in 1956. Till 1947, the area was largely known as Malayala Rajyam with two princely states, Travancore and Cochin and the British Malabar. The first endogenous attempt to imagine Keralam as a unified geographical and political space came from Chattambi Swamikal in 1914 in his book, Pracheena Malayalam (Ancient Malayalam). Other attempts were based on exogenous parameters such as an area with large presence of the Portuguese merchants, or as a residual part of a macro unit, the South India. (See Raju 1999, 1-62)
knowledge in the practice. While *Jyotsnika, Vishanarayaneeyam* etc. are both in Sanskrit and Malayalam (Menon n.d), *Vishachikitsa Ashtangahridayam* is an Arabi-Malayalam text interpreted or translated by Parappurath Illath Beerankutty vaidyar and *Shafashifa* is a text compiled by Konganam Veettil Ahammed alias Bava Musaliar.  

The practice is closely related to *siddhavaidyam* due to two main reasons. Firstly, it uses certain metals such as mercury in treating poison, especially in extreme cases of snake poison when the patient is unconscious and on the verge of death. Secondly, *siddhavaidyam* basically uses metals for *chikitsa* (treatment) after removing the toxic content in them through continuous purification. Thus, *siddhavaidyam* can also be seen as *vishavaidyam*; but every *siddha* practitioner does not administer poison treatment directly. *Marmavaidyam* and bone setting are common among *kalari* and *siddha*, whereas use of certain metals and pulse reading are common among *vishavaidyam* and *siddha*.

*Siddhavaidyam* is mostly prevalent in Tamil Nadu and the Southern parts of Keralam. It is significant to note that *siddhavaidyam* was known as Tamil medicine or Tamil Ayurveda until nineteenth century (Sebastia 2012, 165-185). The term ‘*siddhavaidyam*’ was used to denote the healing form that had a Dravidian identity and it was known as a Tamil variant of ayurveda (Weiss 2009; Kumar and Basu 2013, 23-39). In short, practices such as *kalari, vishavaidyam, siddhavaidyam* or ayurveda overlap with one another in medicine and treatment and have spiritual and material dimensions. Ayurveda as we know it today, the institutionalized and coherent system never represented all of these practices despite the fact that it assimilated many elements from them. The term ayurveda did not emerge, as represented today, as a textual, erudite and systematic tradition.

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16 See *Bhodhanam* Quarterly 2015, Vol.15, No.11, Swalahudheen, *Chikitsayude Sastrareethikalum Muslingalum*. 

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of Keralam till mid-nineteenth century. It existed as a composite group of heterogeneous elements, interchangeably called ayurvedas or nattuvaidyam. The heterogeneous group consists of practitioners with different pedagogical backgrounds and social status. The marginalized practices also negotiate with the changing order of their status in interesting ways. For instance, healing practices such as kalari, that usually did not follow the humoural base of bodily disposition began to claim this idea from the late nineteenth century onwards and empowered itself as part of the more accepted ayurveda.

Practice, language and region: a conjoining of distinctiveness

Until mid-nineteenth century the need to name medical practices either as Siddha or ayurveda and Dravidian or Aryan, by connecting practices with the unique identity of regions and clans, was not present. ‘Nadu’ and nattuvaidyam itself represent the indigenous and regional nature of the healing practice. The boundaries set for each region in the late nineteenth and twentieth century invited unique identities and titles for their cultural practices - as kalari, siddha and ayurveda. This in turn began to represent the markers of particular regions or the nation - state. By twentieth century, Siddhavaidyam began to represent the special indigenous medical form of Tamil Nadu with a Dravidian past (Trautmann 2009), Kalarippayattu represented the unique martial art of Keralam and, in

17 See chapter 2 which delineates the processes of assimilation of medicines and chikitsa and the simultaneous differentiation of diverse nattuvaidyam from an institutionalized and systematized (modern) ayurveda.
18 Interview with Sathyanarayanan, Trivandrum on 12.06.10 and Balan Gurukkal, Kozhikode on 02.05.14. Both of them firmly believe that kalari treatment is based on the humoural principles of ayurveda. All other kalari practitioners I interviewed strongly reject this ayurvedic humoural association.
19 Trautmann argues that the Madras School of Orientalism initiated a platform to question the Aryanised and Sanskrit origin of languages by bringing in to the stage the Dravidian proof of Tamil language (Trautmann 2009, 1-25).
most written works, it is also associated with the traditional occupation of one particular caste, the nairs (See VijayaKumar 2000, Zarrilli 1998). Ayurveda began to be represented as the unique practice of India, and as one inherited from an Aryan origin. The Orientalist perspective inaugurated by William Jones and Thomas Colebrooke posited a Vedic Golden Age (Ganesan 2010) constituted by the Aryan Hindu and their Sanskrit texts as the base of Indian civilization (Kopf 1969). The practitioners of ayurveda and the scholars who studied ayurveda in the early twentieth century subscribed to this idea (For this ideas see Muthu 1913, Varier 1906).

The practices were not only tied to regions and clans, but also to languages that spilled over the strict boundaries of these linkages. Siddhavaidyam was associated with Tamil language, ayurveda with Sanskrit (Weiss 2009), northern kalari with Malayalam and southern kalari again with Tamil. Since ayurveda come to be elevated as a traditional knowledge of India, it acquired the responsibility of representing an indigenous Indian healing tradition or medical practice. In other words, ayurveda began to wear the most prestigious crown amongst all these practices as it come to be represented as the unique practice of a nation-state, whereas the identities of other practices were tied to the respective regions. However, in the nineteenth century, while certain practices acquired a distinctive indigeneity associated with the newly bounded regions, certain practices lost their indigenous nature with some elements of them being assimilated to the reconstituted ayurveda. Thus some of the unique practices such as uzhichil (medicinal oil massage), pizhichil (oil bath), kizhi (medicinal pouch) and talam (clogging oil on the pate or around the eyes) that prevailed in Keralam became part of ayurveda, even when these particular treatments were not seen in the
ayurveda practised in other parts of India (Varier 1980, 308; Unnikrishnan 2011). These practices were part of kalari and adimurai and even within the two streams, there were differences in terms of the medicines used and the nature of massage given. Pizhichil and talam cannot be integral to adimurai of southern Keralam where use of oil is not a necessary part of the training. In northern Keralam, oil massage is an integral part of kalarippayattu and so is pizhichil as a treatment from the northern kalari (Vijayakumar 2000). The wooden table - dharapathi - specially designed for the above treatments is another contribution of nattuvaidyam (Asan 2010). Another aspect of interest is that when ayurveda and siddha begins to represent two separate regions, the meaning of nattuvaidyam, which had been used to represent all the diverse healing practices including ayurveda and siddha, shifted. It came to be seen as representing diverse indigenous medical practices excluding the institutionalized and formalized ayurveda and, later, siddha too, since the latter took much more time to get institutionalized as a separate practice of Tamil Nadu. This identification and representation also positioned unani as a medical practice of one particular community despite the fact that all these practices shared and borrowed medicines, treatments and herbs from each other (Ali 1990).

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20 Interview with Raveendran Asan on 7.5.2011 and Thankappan Asan on 8.5.2011. Both practitioners are from south Keralam. Even today the southern kalari do not use oil massage before the daily practice of kalarippayattu. One of the differences between the northern and southern kalari is that the former applies oil massage before the practice. Interview with Madhu Pudupanam on 27.11.10, and Karunan Gurukkal, Vattoli on 30.05.10. Both these practitioners are from north Keralam.

21 Tablets such as kombanjadi, gorojanadi and oils such as murivenna were unique medicines used by native practitioners though one cannot clearly state whether they derived from unani or ayurveda. Now they are known as ayurvedic medicines of established ayurvedic systems. (Unpublished Ph.D thesis of Pramod 2010); Choorakkodi Kunji Moossa Gurukkal, Villiapalli in an interview dated 27.11.2010, mentioned that kombanjadi gulika (tablet) originated from Persia. One cannot deny this connection considering the mutual interaction between unani, ayurveda and native medical practices.
the Muslim community (Weiss 2009, 6), despite its overlapping with other indigenous healing practices (Quaiser 2001, Attewell 2007). At the level of practice there are similarities and interactions, but on the socio-cultural and political level, relationships are built around enmity and tension (Bode 2013, 22).

In this study, these practices are selected as examples for locating the transformations and survival strategies of the larger realm of nattuvaidyam. They generally follow the concept of bodily humour in diagnosis and treatment. However, a few other criteria are also considered for selecting them. Kalari has been studied by many scholars in detail (see Vijayakumar 2000, Zarrilli 1998) but the healing aspects of kalari have been looked into by only a few (See Sasidharan 2006). The existing studies largely focus on the performative element in kalari, the kalarippayattu of the nineteenth and twentieth century (Vijayakumar 2000, Zarrilli 1998). Kalarippayattu was generally considered as a martial art and the healing tradition inherent in it was subsumed and described in the late nineteenth century as a common feature that existed in other martial arts like wrestling. The bone setting aspects in kalari which requires precision has not been studied seriously as a treatment as it often counterpoised against the surgical part of modern medicine. The healing element in kalari follows not merely the humoural theory of nattuvaidyam vis-à-vis ayurveda (Zarrilli 1998, 163); it is based on 96 principles of the body, an entirely different approach from the humoural perspective (Asan 2010). The idea of the body varies from practice to practice despite the fact that they all follow the larger humoural principle. Later, the attributes of this principle was integrated into many practices that basically

22 Both Vijayakumar and Zarrilli say very little about the aspect of bone setting in kalari.
23 Interview with Kishore Gurukkal on 24.1.2013 and Prakasan Gurukkal on 27.1.2013. Both are kalari practitioners from Kollam district.
24 See chapter 4 in which the idea of body in nattuvaidyam is delineated.
did not follow this idea of body (Langford 2001). This study focuses on the healing tradition in kalari without reducing it to kalarippayattu, the physical exercise, which is inclusive of the idea of ‘care of the self’ through bodily manifestation.

Similarly, vishavaidyam also remains less studied and is seen as an area that is deficient in sources for a historical or sociological research. The irresistible reliance of history on textual sources (Mukharji 2011) also places the tradition of vishavaidyam outside the corpus of the history of indigenous medicine. Available studies approach the subject from the perspective of modern science. It was seen as a branch of ayurveda, as a chapter in Ashtangahridaya is on vishavaidyam. However, there are diverse methods and medicines used in vishavaidyam for the treatment of poison which are not part of ayurveda (Varier 1980). The texts (both oral and written) used to learn vishavaidyam are in verse forms and consist of an array of descriptions on the variety of snakes, animals and plants; food that cause poison; symptoms in each case of poison; different kinds of medicines to be used in each case; dietary regimen and the signs to be elicited from the messengers who come to inform about the case of poisoning (this is especially for snake poison), etc. These texts are a repository of descriptive and prescriptive aphorisms. At the level of practice, the practitioner is entrusted with the responsibility of deciphering their meaning through experience and expertise. Texts function as a handbook for the practitioners as well as a repository of information for layperson who are interested in the subject. Earlier these texts were not meant for people outside the realm of the particular knowledge and practice that the texts represented. One needs to acquire certain a priori

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25 See the works of Dr. Adiyodi 1965 and Dr. Manoj Komath 2011. Also see chapter 5 in which the tensions and controversies around the debates are discussed in detail.
knowledge and capacities not only to read a text but also to understand its intricacies and nuances. Knowing the contextually differing meaning of the terms used in the texts is decisive in their application.

Until the early decades of twentieth century, *vishavaidyam* was well established all over Keralam with the patronage of kings and land lords and there were plenty of grant-in-aid *vishavaidyasalas.* In the contemporary era, however, the practice lost its mooring and became scattered all over Keralam because it did not have any support from the state or society. Being an area that has not been studied in detail so far, *vishavaidyam* invites our special attention in delineating the internal logic within it and the transformations it has undergone over the course of time. The present study attempts to stretch the internal descriptive and prescriptive nature of the practices to some extent, and allows them to speak for themselves rather than analyzing the meaning and scientific validity of every aspect of this research object. This study thus challenges the application of a hegemonic reasoning to locate and understand practices that function within a different mode of reasoning. The outcome of this strategy would be to lay out the internal logic of the practices to some extent and the nature of *yukthi* (rationale) applied at different levels of the practice.

All *vaidyas* were known and called as *nattuvaidyas* till early nineteenth century, but they become demarcated into *nattuvaidyas* and *ayurveda vaidyas* by the late nineteenth century. In the late nineteenth and early twentieth century the documents pertaining to *nattuvaidyam* in the Madras Presidency were classified under the category of Indian System of Medicine. By the second decade of the

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27 Folklore studies attempts to document *vishavaidyam* as a locally available knowledge and cultural practice that is embedded in rituals and beliefs. A small number of MA dissertations in the Folklore Department, Calicut University has documented the practice of a few practitioners.
twenty-first century, a Department of Ayurveda was constituted, especially in Travancore state and all files pertaining to nattuvaidyam began to be dealt with by this department. Inspection Reports of the Superintendent of Nattuvaidyasalas (indigenous pharmacies) in the 1920s and different government documents show this shift. By the mid-twentieth century, the latter group was designated as ayurveda doctors by eliminating the diverse titles awarded for vaidyas from different educational institutions (Mohanlal 2014). The change in designation that began in the early twentieth century and was institutionalized by mid-twentieth century is not merely a difference between formally and informally qualified practitioners. It is equally a change in their social status and a demarcation between qualified and less qualified or seemingly non-qualified practitioners. This segregation was based not merely on their formal or informal access to knowledge in ayurveda. It was premised upon other tangible elements such as proficiency in Sanskrit, English, modern physiology and anatomy. It was also in terms of the titles awarded after graduation and specialization from modern educational institutions. This differentiation added a new layer of meaning to the term ‘quack’ by categorizing many of the non-institutionally trained practitioners as quacks. In the late nineteenth century, quacks included biomedical practitioners and indigenous practitioners who did not have formal training, or students who had failed from medical institutions but had resorted to practicing

28 Codell Carter observes that historical debates of quackery are generally anecdotal, and hence more entertaining than enlightening. (Carter 1993, 89-97). A quack is a charlatan who dishonestly claims to have special knowledge in medicine. In the context of modern medicine and vaidyam the meaning of the term quack has shifted. The Usman Committee Report defines quackery as follows, ‘practice the art of medicine without a study of the science on which the art is based quackery, whether this undertaken by the followers of Indian or European medicine’ (See The Usman Committee Report 1923, Part I,14). While accepting the resolution moved for the promotion of Indian systems of medicine in the Council of State in 1921, Sir Pardey Lukis had stated that “the spirit of medical trade unionism leads many modern doctors to stigmatize all vaid and hakims as ‘quacks’ and charlatans. See G.O No.1339 PH dated 14.10.1921, Local Self Government department, Miscellaneous,TSA.
medicine (Carter 1993, 89-97). By the early twentieth century, biomedical practitioners viewed all *vaidyas* as quacks and by mid-twentieth century, both biomedical and ayurveda practitioners regarded all *nattuvaïdya*s as quacks. Thus the differentiation portrayed differently trained practitioners as non-qualified practitioners. What does this measure of qualification mean to the practice? This significant question is yet to be thought through as many ayurvedic graduates of non-*vaidya* families often approached *nattuvaïdya*s to learn ‘more’, not only in the twentieth century, but even in the contemporary.  

**Contextualising the research**

Ever since the reassertion of indigenous medicine with the advent of biomedicine in the nineteenth century, scholars observe that social sciences have paid little attention on studying indigenous medicine (Sujatha 2014, xi). While there have not been many studies within the discipline of social sciences on indigenous healing knowledge and practices, within anthropology and later, in history, there have been some attempts to probe these practices. Being a study that aims to understand the transformations and internal tensions within *nattuvaïdya*m vis-à-vis ayurvedas, as well as their external tension with modern institutions and biomedicine, the present study faces a few challenges. The models set in studying the historiography of indigenous medicine of South Asia, across the disciplines of history, sociology and anthropology exhibit some common trends that spilled over their strict disciplinary boundaries. This study proposes three departures from the general trends seen in literature.

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29 Two ayurveda students were learning *vishavaïdya*m from Basheer *vaïdyan* at Feroke, Kozhikode, when I interviewed him three different times in different months in 2010. Five students were studying under Brahmadathan Nampoothiri, Thrissur, at the time of my interview in November 2010. They were learning *Jyotsniaka*, a *vishavaïdya*m text, and *Ashtanga Samgraha*, an ayurveda text.
Erudite and non-scholarly

A major propensity in the scholarship on indigenous healing practices is to divide them neatly as erudite tradition and marginalized oral tradition (See Leslie 1976, Panikkar 1995, Mukharji 2012). The implied perspective is that the erudite practice belongs to a singular conception of ayurveda which follows a textual tradition, whereas the marginalized traditions hail from mostly non-textual/oral spaces and are heterogeneous in nature. The idea of this separation is flawed since many practices such as siddhavaidyam, marmavaidyam and vishavaidyam have a textual basis too. If we see them as separate realms of erudite and non-erudite practices as in the above mentioned studies, both do not necessarily follow texts in the realm of practice. The texts may function as reference materials at crucial times during practice. This study departs from the neat division between scholarly textual tradition and non-scholarly non-textual tradition, and prioritizes the shared elements in the practices and their continuous overlapping nature. The challenge here is to avoid duality while situating the incessant sharing and negotiating nature of the erudite and marginalized heterogeneous practices. It is extremely difficult to differentiate them neatly as erudite or non-erudite; the propensity to see them so stems from the writings of colonial administrator-scholars (Wise 1845, XV) and indologists (Wujastyk 1998, 2) that functioned as a base model for future scholarships produced in the area.

North India as the model

The second protocol that prevailed in academia was that the healing practices of South India were seen and studied in the context of the information and knowledge produced in North India (Trautmann 2009, 1-25). This is not to claim that the whole of South India has a uniform identity with homogenous practices
and forms of languages that represented these practices. They were diverse in such a way that it was difficult to bring them under any one school of thought. It is also not to imply that South India and its practices have some unique features that differ from that of North India. What is to be emphasized is that the earlier Orientalist perspective of an Aryanized and divine past, evolved in the context of studies on North India, gets reflected in a sophisticated manner in some of the significant scholarship on South India. They did not reproduce an Aryanised classical ayurveda, but invented a Sanskritic, textual and elite tradition as that of a classical ayurveda. This erudite tradition was seen as a model for the scattered and marginalized, vernacular practices to imitate and assimilate (Leslie 1976, Panikkar 1995). What is implied in this perspective is that knowledge always trickles down from the top to the bottom. Leslie says, “Folk cures throughout the world practice humoral medicine, but in Asia alone educated physicians continue its learned tradition” (Leslie 1976, 1). Leslie combines education and literacy as a non-separable theme whereas Panikkar clubs literacy with an elite class, thus imbuing the idea of an elite literate practitioner as one who practices ayurveda against the marginalized non-literate practitioner (Panikkar 1995, 317-355).

In contrast to the views on an Aryanised past, the Madras school of Orientalism initiated a debate on a Dravidian origin (Trautmann 2009). This view was reproduced in studying certain indigenous healing practices such as siddhavaidyam, as having a Tamil textual tradition (Weiss 2009). The conception of this Dravidian past was also an attempt to defy having to accept a homogenized Aryan past (Trautmann 2009).

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30 Basham explicitly states, “Indian medicine reached its classical form in the early centuries of the Christian era, the period crowned by the dynasty of the Imperial Gupta.” (Basham 1976, 18-43)
Science sets the stage

The third challenge addressed in the present study is that science and its protocols and method overshadowed the study of indigenous healing practices. Biomedicine and science set the stage for debates on public health, hygiene and social sanitary measures. Traditional healing practices were studied as opposed to the scientifically proven modern medicine by applying the norms of the latter in situating the former (Abraham and Sujatha 2009, 35-43). They were studied as practices inseparably associated with religion. Thus by definition they were dissociated from the scientifically designed and defined modern arena of knowledge. Anything that deviates in addressing a ‘public’ or ‘social’ body directly and not through the norms under which modern knowledge intends to intervene in these fields are considered as incompetent and irrelevant. The ‘public’ and the ‘social’ bodies in this formation imply an emptying out of culture by replacing it with seemingly culturally neutral concepts like secular and universal. The historiography of South Asian medicine initially started from the state-centric discourses of public health (Arnold 1989, 1993, 2000; Harrison and Pati 2001, 2009). While being conscious of these formulations, the study will temporarily suspend these propositions whenever necessary, in order to bring out the nuanced relationship among practices and the continuities and ruptures that emerged out of this fashioning of the practices.

Scholars emphasized the cultural project of western medicine in ‘colonizing the body’ of the natives in its ‘civilizing mission’ (Arnold 1993, 1-11). However, the role and contribution of indigenous medicine in intervening and curing certain

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31 His Excellency’s reply to the address presented at the opening of the Ayurvedic dispensary at Cheruthuruthy, Shoranur. See G.O No.475-476 dated 19.11.1917 Local and Muncipal Department, Indigenous System of Medicine, TSA, 17.
diseases defined as contagious and hazardous to the public (body) has not been studied with due seriousness. The new notion of public health also seems to have initiated a chain of exclusions, by presuming that indigenous medical practices do not have any idea of public health as they deal with individual bodies and body-specific humoural treatments. Public health presumes the presence of abstract bodies in public display that are vulnerable to epidemics and infections, and need to be controlled through large-scale preventive and sanitary measures. The state-centric medicine or biomedicine and the state itself cannot function in full without having the inter-related imagination of a public (body) out there to be governed and normalized through a series of interventions. This public body is an individual as well as social body, which differs from the hitherto existing ideas of individual body where the responsibility of taking care of the body and self rests with the person but not in relation with a nation-state. In other words, social bodies and their interactions are presumed as having an *a priori* existence that invites not only contagious diseases but also intervention through public health measures.

The scholarly discourse on health vis-à-vis public health, has not considered the wide popularity and role of indigenous medicine in inculcating and disseminating the practices and knowledge of health.\textsuperscript{32} In the late nineteenth century indigenous healing traditions were counted as traditional religious spaces of culture and never considered as knowledge. The condition for becoming knowledge primarily requires a distancing from the realm of religion. It is well-known that in the initial years of the advent of biomedicine in India and elsewhere, the colonial state sought the support and knowledge of indigenous medical practitioners to

\textsuperscript{32} For instance see Arnold 2000.
reach out to a wider population with its vaccination and other measures to control contagious diseases (Pathi and Harrison 2009). The British medical policy also encouraged Indian drugs and allocated funds for purchasing bazaar medicine (Ramanna 2006). By the late nineteenth century, this co-operation and utilization of indigenous medical knowledge ceased due to the increasing professionalization of biomedicine (Bala 1991). Subsequent attention and interventions of biomedicine extended to the area of reproductive health and here the indigenous epistemology of birthing and the knowledge of dais (traditional midwives) were not considered as valid knowledge. In the contemporary context, the role of dais in aiding the delivery of a baby is almost eliminated. The role was later reintroduced as that of caretakers who provide post-delivery care to the mother and the baby (Sujatha and Abraham 2012, 9). In effect, discourses of public health completely erased the role of indigenous medicine, despite the fact that it was widely utilized by the people, either alone or along with biomedicine, for preserving or regaining health without bothering about the curative or preventive potential. Especially in the case of child birth, people use their own discretion in choosing a biomedical institution for birthing and indigenous medicines for post-delivery recuperation. The contribution of indigenous medicine in the fields of reproductive health and prevention of contagious diseases was not counted as significant in the second decade of twentieth century. Both the fields were demarcated as that which invited the intervention of state/missionary institutions and their valid knowledge. There were instances of indigenous healing practices attempting to intervene in the area of public health, but these were invariably met with enormous protest.
In 1934, when the Ayurveda Patasala of Travancore state conducted a Malaria camp in Edakode, Trivandrum, with the consent of the king, the Resident and Surgeon General met the king to express their protest (Mohanlal 2014, 18-19). Their attempt was to prevent the functioning of the camp as they could not intervene directly in the matters of a princely state. They decided to show a documentary film at Kuzhithura, a place adjacent to Edakode. The documentary depicted the efficacy of indigenous medical practitioners in treating diseases adversely. With the timely intervention of the king, the documentary show was banned twenty-four hours before the screening. The princely state finally conducted the camp which lasted for six months and it was a huge success in curing the people of Malaria (Mohanlal 2014, 18-19). Despite such instances, the role of indigenous medicines in healing malaria, plague, cholera etc. has not been assessed seriously till date though a number of practitioners advertise their medicines widely (through newspapers and health magazines) as being effective in treating such diseases.

During this period, the study on medical practices gave prominent space to western medicine and the subsequent progress of the drug industry in both Europe and in India. Medicine preparation by the indigenous practitioners may be classified under non-modern capitalistic production, as very few of them entered the market to provide large scale supply of medicines. However, by the late twentieth century, scholars began to notice that changes had taken place within indigenous medical practices in creating a niche market for their products and the

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33 750 in-patients and 4800 out-patients were treated and cured in the camp. Patients who needed long term treatment were given medicine and necessary advice for strictly following *pathyam* (dietary regimen) (Mohanlal 2014, 19).
innovative methods in creating medicines with shelf-life both at the individual and institutional level (Banerjee 2009, Bode 2008, Harilal 2011).

The historiography of *nattuvaidyam* has mostly been influenced by official discourse, even when parallel discourses were available within the practices. When studies on indigenous medicine or Indian System of Medicines (ISM) analysed their practices in relation to a state-centric and state sponsored biomedicine, they end up in a comparative framework, bringing out a series of lacks in ISM. Mukharji avers that in the histories of colonial medicine, one of the most widely used terms was ‘encounter’, and this ‘encounter-frame’ helped organizing medical history in terms of a narrative of confrontations between two relatively discrete entities.\(^{34}\) This idea of encounter imagines a confrontation between a well-bounded, discrete western medicine and an equally bounded and homogenized indigenous medicine (Mukharji 2011, 8). Irrespective of such discourses, the nature of the relationship between these diverse practices have often been that of interaction, assimilation and innovation rather than that of competition or ‘encounter’ (Sivaramakrishnan 2006, Alavi 2007).

**Formalization and normativization**

The direct intervention and control of the colonial state necessitated the formalization of certain practices as the authentic indigenous system of a region. Till then, majority of the practices had a claim that they all followed the ayurvedic tradition even when some of them depended on *Ashtanga Hridayam* (AH), some others followed popular vernacular texts like *Chikitsa Manjari, Vaidyasarasamgraham, Vaidyaratnamalika* etc. in the realm of practice (Varier 1980). Another significant point to be noted here is that AH was a basic Sanskrit

\(^{34}\) See Arnold for this view 1989, 1993
text used in Keralam not only for learning vaidyam but also for learning Sanskrit (Mohanlal 2015). While *kalarippayattu* and bone setting does not derive from any of the texts, *marmachikitsa* follows Sanskrit, Tamil and Malayalam texts such as *Marmasootram*, *Marmanidanam*, *Varma Cuttiram*, *Varmakalai*, etc. *Vishavaidyam* follows AH, but has also produced its own unique texts like *Prayogasamuchayam*, and *Kriyakaumudi* in Malayalam, *Vishnarayaneeyam*, *Jyotsnika* etc. in Sanskrit, Tamil, Arabi-Malayalam and Malayalam. The vernacular texts are seen as non-scholarly works (Varier 2009, 9-44) as they are also utilized by people for treating minor ailments. When the intra-cultural negotiation was between indigenous medical practices, the inter-cultural dialogue and sharing was between indigenous medicine and biomedicine, especially in the early twentieth century. The aspiration for a pure and original practice, that follows a pre-given textual knowledge in its realm of practice, leads to fixing the boundaries for each practice in terms of texts used and the language in which the texts are written. Further, state intervention asserts this division through the implementation of law and regulations such as medical registration and identifying quacks. Even in the contemporary era, Sanskrit texts are positioned at the top in a vertical relationship, with vernacular texts at the bottom. The scholarly status of practitioners is assessed in accordance with their fluency in Sanskrit (Report of the Director of Ayurveda 1920) but an ambiguity can be seen within the very assessment.

Vernacular language sources do not follow official protocols and the norms prescribed for being considered as authentic knowledge. They share a peripheral space in the official statistics, reports on the statistics, protocols of the reports and

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35 Interview with Raghavan Vaidyan, Kakkur on 13.05.13 and Avanaparambu Maheswaran Nampoothirri, Wadakancherry on 16.01.2012.
academic studies based on these reports (Mukharji 2011). Yet they open up an array of interesting dialogues that occur between the peripheral place they occupied and the central discourse produced through their very presence. The inter-relationship between scholarly texts and vernacular texts was erased through an isolation of the vernacular resources as a local knowledge source of the ‘kriya-vichakshanar’ and as those associated with home medicine (Varier 2009). While objectifying practices having a marginal value in catering to the needs of the village people, the same process initiates a subjectivization in which these vernacular texts and practices reformulate themselves in a dialogical relationship with the central practices as well as with the state policies. The vernacular texts follow their own textual protocols and were historically produced contingent materials (Mukharji 2011, 30). \textit{I argue that seeing vernacular texts as heuristic devices enable us to see the limitation of the narratives produced and entrenched in institutionalized and officially recognized languages.} This work does not approach vernacular texts in opposition to anything more learned, prestigious and recognized, but sees them as equally valid sources of knowledge.

The history of medicine was always understood as the history of western medicine (Sujatha, 2014, 7).\textsuperscript{38} Whenever the epistemological dimension of indigenous healing practices were specifically asserted in studies, a comparative framework is posited in relation to ayurveda by assuming that it is a coherent and systematized practice that existed across India prior to the colonial regime (Leslie 1976). Later, Langford pointed out that those who perceived ayurveda as a

\textsuperscript{36} Kriya-vichakshnar is a term used in \textit{Dhanwantari vaidya} magazine to describe vaidyas efficient in practice and who use vernacular texts without having a theoretical base as against Sastra nikshnathar, who know sastras and use Sanskritic texts. \textit{Dhanwantari} 1910, January 7:6, 126-128, Editorial-\textit{Anyonyapeksha}.

\textsuperscript{37} G.O No. 475-476 dated 19.11.1917, Indigenous Systems of Medicine, Local and Municipal Department (Medical) 1917, TSA.

\textsuperscript{38} For instance, see the studies of Arnold 1989, 1993; Pathi and Harrison 2001, 2009.
dominant indigenous system of medicine reinstate many peculiar features of a modern organization of knowledge (Langford 2001, 9). In the second half of the twentieth century, Leslie inaugurated the term ‘system’ to classify ayurvedic practices that existed in Asia and titled his edited book, ‘Asian Medical System: a Comparative Study’ (Mukharji 2011). However, it is difficult to locate any set of rules that strictly governs the structure and the seemingly bounded system, not even the humoural perspective of the body (Attewell 2007, Langford 2001). In the context of the study on Unani, scholars point out, “the use of the word system…….consolidates the impression of continuity, connoting internal coherence, discreteness, completeness and homogeneity” (Attewell, 2007, 24). Sociological studies that follow the frame of structuralism to understand indigenous medicine picked out a number of polarities as the founding principle of Ayurveda. Obeyesekere argues that this perspective does not account for the intermediate terms that blur the binary distinction in ayurveda which is crucial in Hindu medicine, but not familiar to the practice of French structuralism. He further states that Zimmerman superimposes modern geography in identifying ancient classifications of diseases and poses the ecological theme of jungle and anupa as the cornerstones of ayurveda and gives little room for messiness and inconsistencies which are common to human life and thought (Obeyesekere 1991, 419-425).

Leslie not only introduced the concept of ‘system’ but also associated Ayurveda with ‘the great tradition’ by categorizing the other marginalized healing practices

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39 For instance see Zimmerman 1982, viii.
40 Zimmerman’s binary distinction between anupa (the region of water) and jungala (the dry climate) regions is central to locate the “collective Indian mentality”. Though he is aware of the intermediate sadharana region, he does not pay attention to this intermediary term and also does not deal with the actual realm of practice. (Obeyesekere 1991, 419-425)
as ‘little traditions’ (Leslie 1976). A handful of nuanced works have also been produced contextually by considering the regional specificities and diversities of indigenous healing practices (Sivaramakrishnan 2006, Alavi 2007, Panikkar 1995, Cleetus 2007). They bring forth the complex relationship between diverse indigenous healing practices and the strategies adopted in their negotiation with not only biomedicine but also the elite practitioners from within. Some of the scholarship, while they do not directly use the ‘little tradition’ and ‘great tradition’ divide (Redfield 1961) or deploy the Orientalist discourse of an Aryanised Vedic and Sanskrit civilization, still follow the basic premise of these discourses by positing ayurveda as belonging to the classical tradition of literate, elite practitioners. All the other diverse and distinct healing practices were by definition located in this configuration as marginalized folk medicine (Panikkar 1995, Leslie 1976). Separating traditions as great and little is premised upon the idea that reformation and learning is a process that has to trickle down from above, from the literate, elite, and hence from great traditions to the oral, marginalised and little traditions (Redfield 1961). It has been pointed out that this differentiation poses a larger global or civilization agenda of reforming the little traditions (Hardiman and Mukharji, 2012, 2).

Another set of studies show a muted anxiety between ‘tradition’ and ‘modern’ as well as ‘science’ and ‘religion’ (Gupta 1976). Here science and biomedicine represent the great tradition. The necessary condition to initiate a dialogue with the little tradition (ayurveda) was to eradicate the non-scientific elements and ritualistic aspects of it. Therefore, ayurveda occupies an in-between position in its dialogue with biomedicine and folk medicine. Its status often changes from centre to margin depending upon the dialogues with the other. The folk medicine
(nattuvaidyam) does not ever get elevated to the centre from the periphery, but its marginality acts as a determining force in shaping the centre, the ayurveda.

Sharma divided the studies on indigenous medicine into those produced in the 1970s and in the 1990s (Sharma 2012) as very few books were published in the 1980s. For Sharma the scholarship of 1990s are an extension of nationalist writings from the 1970s, whereas Mukharji asserts that identifying any single framework or approach is difficult in the historiography of South Asia’s indigenous medical tradition (Mukharji 2012). Until the mid-twentieth century, works on indigenous healing practices were very scarce and were mainly written in the form of ‘Aryavaidya Charitram’ (Varier 1906), ‘Ayurveda Siksha’ (Pathi 1944) and ‘Science and the Art of Indian Medicine’ (Murti 1948) by the practitioners. A set of studies published from 1970s onwards, does address and theorize indigenous medicine directly. They engage with the debates on nationalism (Leslie 1976, Gupta 1976, Bala 2012) and the related discourse of reform and revivalism from within (Leslie 1976, Panikkar 1995). The revitalization represents adaptation and cultural renovation as well as the discourse on indigenous science (Quaiser 2001, 317-355; Kumar 1992). Bala proposes a ‘new paradigm’ as established by the exponents of Indian science, medicine and culture, to contest the imperial policies in the nineteenth and early twentieth century India and she links this paradigm to nationalism (Bala 2012, 1-12). For Bala, this new paradigm produced by the nationalist movement provided a new ‘medico-cultural identity’ to Indian medicine (Bala 2012, 1-12). However, she does not clarify what this body of Indian medicine is and how it has an internal unifying nature, but directly speaks about ayurveda as that which represents Indian medicine (Bala 2012, 1-25).
Critiquing and drawing from Orientalists

While delineating the internal tensions within *nattuvaidyam*, scholars have proposed cultural ideology as a tool that is used to resist the state supported hegemonic knowledge forms (Leslie 1976, Gupta 1976, Bala 2011, Panikkar 1995). Even while critically responding to the Orientalist perspective of an Aryanised golden past of India, the scholarship that studied indigenous healing practices begin to assimilate many of the ideas suggested within the same Orientalist perspective. They projected the textual, Sankritic and literate tradition (a clubbing together of three different features) as the genuine tradition of India. ‘Authentic’ ayurveda was thus located in the ancient Sanskrit texts rather than in the field of actual practice (Langford, 2011) because in the field, it would have been difficult to project any one ayurveda as the authentic practice.

The Orientalists provided an ideological platform for an indigenous movement that had begun to transform medical learning in modern south Asia (Banerjee 2012, 29-50). This indigenous movement was immediately and comfortably linked to a literate and textual tradition. And the major treatises, the ‘*Brhatrayis*’, became “points of authoritative reference for medical practice” (Banerjee 2009, 18). The thrust on a point of origin was present in the studies of the twentieth century, though they did not present that origin as the golden Vedic past of ayurveda emphasized by Orientalist studies. The earlier studies spoke of a coherent, systematized and textual tradition of elite class/caste practitioners which existed and derived from the pre-colonial period. In other words, the methodological constraints of accessing a non-literate tradition from the field of practice limits the framework of the scholars who reached a consensus on

41 *Charaka Samhita, Susruta Samhita and Ashtanga Hridayam* are known as the ‘*Brhatrayi*’s.
identifying ayurveda as a Sanskrit, text-based and hence literate medical practice. The interesting and contradicting aspect of this formulation is that while texts were assumed as providing rules and guidelines for diagnosis and treatment as well as reflecting the development of an erudite culture in ayurveda, its field of practice is described as that which shows the decline of ayurveda from its past glory (Langford 2011, 9). What constitutes a pure ayurveda is an ambiguous question even in the contemporary. The modern ayurvedic educational institutions have not solved this riddle either. Langford elucidates this:

In the world today, the practices that a particular patient or healer might consider in/as ayurveda range from urban South Asian home remedies based on an understanding of “hot” and “cold” foods to the medicinal herbal lore of the countryside, standardized ayurveda as taught in Indian or Sri Lankan colleges and eclectic practices taught in workshops in Europe, North America, and elsewhere and geared to an international clientele. (Langford 2004, 4)

Reading the transformations in vaidyam through the grid of nationalism provides one type of focus, centered on revitalization and recouping ‘tradition’ from a decaying past. But temporarily suspending this paradigm reveals some interesting moments in the survival strategies and market negotiations of indigenous healing practices. It also encourages one to see the ‘non-coercive reordering’42 of indigenous medical practices while negotiating with the internal and external tensions. The internal tensions are related to the differential social status and entitlements of vaidyas hailing from a range of castes and communities and following a variety of practices and learning methods (Sivaramakrishnan 2006, 42)

42 ‘Non-coercive rearrangement of desire’ is a term used by Spivak while speaking about the role of Education. (See Spivak 2004, 523-581)
Alavi 2007). The external tensions of indigenous medical practices are sometimes with the institutionalized ayurveda, and at other times with institutionalized biomedicine, mostly with both of these practices which are patronized by the state, which accords them differential status and priorities. My study focuses on pinpointing the negotiations of the practitioners in their survival strategies to cope with the demands of a new scientific consciousness and an emerging market looking for alluring products. My endeavour is to outline certain moments of rearrangement, re-figuration and transformation or, rather, ‘productive self-formation’ in the whole process of negotiating with the state, biomedicine and the newly produced, institutionalized and systematized ayurveda. Many particular healing practices that existed in certain parts of India from the nineteenth century become part of ayurveda by early twentieth century. These incorporated elements of knowledge have enhanced the authority and authenticity of ayurveda as the sole indigenous healing tradition of India. At the same time, the processes erased or devalued many practices by terming them as quackery and folk practice.

From the early twentieth century itself a number of books on the history of vaidyam were written by practitioners of indigenous medicine as well as biomedicine. The majority of these works derived from the Orientalist discourse and presented ayurveda as a coherent, systematic practice that existed in India prior to the Buddhist period with a divine past that is lost from the Mughal rule onwards and decayed further during the colonial period (Varier, 1906; Muthu).

43 Taking a cue from Foucault, Mukharji avers that western medicine’s role as a ‘repressive’ force has been studied widely, but its ‘productive’ role in constituting new subjects and subject-position has not been explored. He further points out (through the works of Vaughan 1991 and Anderson 2002) that both repressive control and productive self-formation have been the consequences of colonial medical power whereas only the former aspect has been projected in scholarly works (Mukharji 2012, 9-10).
44 Krishna Varier was an ayurveda physician.
45 Chowry Muthu was a biomedical doctor.
1913; Mukhopadhyaya 1923). These works largely derived their ideas from the texts produced prior to this chronological period, especially the text written by Bhagvat Sinh Jee in 1896 and another in 1845 by Wise T.A, a surgeon in the Bengal Medical Service. They continued to influence subsequent works which is reflected even in contemporary studies on indigenous medicine as mentioned earlier. Uma Ganesan writes,

Written in 1913, nearly a century after the British abandoned the Orientalist discourse, Muthu’s account demonstrates the continued power of that discourse in lending credence to identify construction and national consciousness among elites in colonial India. (Ganesan 2010, 113).

There were other serious attempts in the first half of the twentieth century to interpret the principles of rasasastra by Lakshmi Pathi (1944) and Ray (1903) which could be seen as a different practice that overlap with ayurveda and are intimately indebted to each other. These painstaking studies which explain the principles and internal logic of ayurveda and siddhavaidyam invite less attention than the studies on the history of ayurveda across India. The ideas produced in the academic works of the 1970s often reflect the ideas spread through the earlier histories of ayurveda as well as the perspectives shared in popular memories of the practitioners even though the language of articulation and conceptualization were different (For instance, see the works of Leslie 1976, Gupta 1976, Basham 1976, Kutumbiah 1962). In order to speak about indigenous healing practices, it appears that it was essential to locate them within the fold of history rather than in the realm of present day practice in spite of the fact that this history was often dug out from a divine Vedic past with divine attributes.

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46 Varier explicitly says that he follows the model set by Bhagvat Sinh Jee (Varier, 1906). Sinh Jee was the Maharaja of Gondal, Fellow of the Royal College of Physicians of Edinburgh, and the Vice President of Indian Medical Association.
The early twentieth century witnessed the proliferation of a series of texts in nattuvaidyam, in the newly evolved genre of prose. They re-described the knowledge in vaidyam in an explanatory language, in contrast to the earlier prescriptive language. The production of these texts increased immediately after independence. P.C. Ray’s History of Hindu Chemistry (1903) and B.N. Seal’s The Positive Science of the Ancient Hindus (1915) and others were texts published in the early twentieth century (Banerjee 2012, 36). P.S. Variers’s Bruhat Sareeram, Lakshmi Pathi’s Ayurveda Sikshaa and Sreenivasa Murti’s ‘The Science and the Art of Indian Medicine’ were published after 1940s as attempts to highlight the sections that dealt with ‘physiology’ and ‘anatomy’ in ayurveda, fields that were prominent in biomedicine (Banerjee 2012, 36). Indigenous medicine too could not escape the compelling requirement of the period to have texts that represent and validate certain specific fields of knowledge. Texts in verse form narrating diseases, symptoms and medicines were perceived as incoherent and irrational. Thus subject-wise and theme-wise prose began to replace the existing aphoristic texts in verse form in which the boundaries of contradictory fields used to flow and blur without inducing any tension. The making of prose is also a process that defines what could come under the scrutiny of rational thought and what was to be eliminated.

Of late, scholars have also classified the nature of studies in indigenous medicine as ideological, anthropological and socio-historical (Mukharji, 2006). According to Mukharji, the Indologist studied Sanskrit canons (of ayurveda) to unpack the evolution of conceptual medicine. The anthropologists, who explored folk beliefs focused on the impact and responses of socio-political context of colonialism on indigenous medicine. The folk beliefs were always placed beneath the classical
tradition and the socio-historical studies. The socio-historical studies invariably looked upon the classical tradition, even to locate the folk practices. Mukharji also acknowledge that a division between folk practices and ayurveda is indeed possible not only in terms of practice, but also at the conceptual level (Mukharji 2006). The present study, however, contests the idea of a clean demarcation between practices that could be classified as folk and classical, or nattuvaidyam and ayurveda, especially in the context of vishavaidyam and kalari, not only in the twentieth century, but also in the present. Such a demarcation became more solidified from the mid-twentieth century onwards, when the governmental process (of modernization) invaded all areas of medicine including the educational institutions, systems for imparting vaidyam, the criteria adopted for fixing qualification and titles for the practitioners, the different titles and differential qualifications given to people who were trained differently through modern institutions or with non-modern methods, the preparation of medicine according to the standard fixed by governing bodies, the equipment used in treatment, the systems for selling registered medicines through approved outlets, etc. The argument proposed here is not that there is an absolute similarity in all the practices, but that there is continuous overlapping and sharing of elements within them. This makes it difficult to separate them out as exclusive fields of erudite and marginalized practices or as independent entities. Though the practices are situated within the boundaries of Keralam, the study of the transformations they went through has relevance in a larger context.

The present trend in studying indigenous healing practices that started from the early twenty first century can be divided into two streams. One of the streams perceives the system as a whole as ‘pluralistic medicine in a given setting,’
including all forms of medical practices varying from folk to ayurveda to modern medicine (Sujatha and Abraham 2012). While many of the scholars study marginalised practices which have a close overlap with the classical ayurveda or siddha, they name the practices within the larger umbrella of medical pluralism (Sujatha and Abraham 2012). Mukharji has observed that the concept of medical pluralism repositions the patient rather than the State at the centre of medical history, by providing a wide variety of choices for them (Mukharji 2011, 16).

The second stream approaches the marginalised healing traditions or folk practices that are not sanctioned and regulated by the state as constituting a realm of ‘subaltern therapeutics’ (Hardiman and Mukharji 2012, 3). The scholars also consider the subaltern experience of statist medicine (biomedicine or AYUSH) for examining the ‘medical subalternity’. Thus, they separate the field of folk medical practices exclusively as an object of study while acknowledging their interconnectedness with the domains of statist medicine.

All the above studies and perspectives put on the table a number of insightful ideas and approaches, despite the fact that the centre-periphery idea\(^{47}\) or the vertical model is prevalent in them. Either the state-centric and state-supported modern medicine represents the centre, or the classical, textual ayurveda as a systematised and codified system represents the centre, according to the form of the particular study. Different perspectives for distinguishing the classical and the folk or ayurveda and popular practice can be located in them. Some studies differentiate practices as those strictly following textual traditions and those

\(^{47}\) The centre-periphery model conceives of a spatial metaphor to describe the structural relationship between the advanced metropolitan centre and the less developed periphery. In this economic model, under-development is a necessary condition for the capitalist development in the centre. (See [http://www.encyclopedia.com/doc/1O88-centreperipherymodel.html](http://www.encyclopedia.com/doc/1O88-centreperipherymodel.html) accessed on 27.08.15).

**Ayurveda in Keralam**

Let us now look at two of the more nuanced works on the indigenous medical practices of Keralam. Panikkar emphasizes that at least in Keralam, indigenous medical knowledge was not the preserve of any particular caste, and not limited to the eight upper caste families of *Ashtavaidyas.* While acknowledging this, he contradicts himself, stating that those who constitute the elite, literate practitioners are proficient in Sanskrit texts. In this formulation, through a coupling of literacy and class and by undermining the element of caste in this pairing, Panikkar assumes that the literate community is always constituted by the elite practitioners. In the field of *vaidyam,* caste and community play crucial roles in determining the social status and acceptance of the practitioners. Panikkar does not count the practitioners who learnt *vaidyam* through vernacular texts as literate (or literate enough) because he too follows certain norms set by the Orientalist studies on the subject. For him, when literacy is mandatory to become part of an elite class, the necessary condition to become literate should be a literacy embedded in Sanskrit. He further asserts that ayurveda or the classical tradition does not see the marginalised practices as adversaries but as an object of reform.

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48 There is more than one view on who constitutes the *Ashtavaidyas.* Brahmin *vaidya* families who are well versed in the eight specialized branches of ayurveda are seen as belonging to the *Ashtavaidyas* (Varier 1980). According to this view anyone who specializes in the eight streams of ayurveda should have the qualification to become an *Ashtavaidya.* Then why did this not happen is a question that needs to be asked. The other view identifies eight Brahmin families of Sanskritic *vaidyas* as *Ashtavaidyas* (Abraham 2013, 32-33). The third view sees eighteen Brahmin families of Sanskritic *vaidyas* as *Ashtavaidyas* (Leela 2008). The fourth view sees *Ashtavaidya* practice as a unique amalgamation of the codified ayurvedic knowledge and non-codified folk medical tradition (Menon and Spudich 2010). Though the first three views agree with the third one, none of them reflect on why only one caste is associated with *Ashtavaidyam* and what additional qualifications makes them *Ashtavaidyas* apart from knowledge of the eight branches in ayurveda.
(Panikkar 1995, 145-75). This theorization denies any agency for non-textual traditions or popular practices to re-innovate themselves, by seeing them as mere objects of reform. He thus denies any agency to the popular practices to initiate a reform from within and attributes the ideal role of reformative attempts to a class that is not only literate but also elite. In spite of these limitations, Panikkar’s study is one of the first to bring out the complex relation between marginalised practices and ayurveda and the way ayurveda further marginalised them (Panikkar 1995, 145-75).

Another set of ideas see medical practices of the recognized elite or upper caste physicians as comprising the classical tradition of ayurveda as against folk practitioners. (Burton 2007). Here, unlike the formulation of Panikkar, the elite are not merely a class that constitutes literate practitioners; it is explicitly also a group of castes. Burton extends Panikkar’s argument by bringing in an aspect of the reform initiated by the upper caste Brahmin practitioners; their teaching vaidyam to the Ezhava medical practitioners, a lower caste in Keralam. He says that through this learning process the Ezhava vaidyas learnt the techniques of the upper caste practitioners, thereby losing their own unique practices. Burton also perceives the learning as a one way process, thus denying the lower caste any role in negotiating with the knowledge of the upper caste practitioners and enriching their own knowledge in vaidyam.49 However, Burton argues that “the ideology of the indigenous medical knowledge and tradition based primarily on Sanskrit and refigured as ayurveda was a distinct phenomenon of the late nineteenth and

49 A similar theorization occurred in the context of Goa where the Medical School of Goa has been studied as a Portuguese-founded institution in which local knowledge and resource had no role at all. This was challenged by Cristiana Bastos’ study in which she provided enough sources to assert that “knowledge also flowed the other way around from indigenous practitioners to their counterparts” (Bastos 2012, 13-28).
twentieth centuries” (Burton 2007, 80). While Panikkar mostly utilizes sources from the Kottakkal Arya Vaidya Sala and its principal founder P.S.Varier to theorize about the realm of indigenous medicines of Keralam, Burton looks at the sources from Travancore state and analysed Malabar through Kottakkal Arya Vaidya Sala. The different locations and exclusivity of the sources enable the scholars to theorize certain aspects within the practices.

These scholarships brought out nuanced perspectives in their study of indigenous practices of Keralam. However, they failed to see the active roles of vernacular literate, non-literate as well as lower caste practitioners in negotiating with and contributing to the modernization of a systematised and institutionalised ayurveda. The idea of an already existing erudite realm of practice denies the epistemological significance of all nattuvaidyam and their unique methods in/of treatment. Many of the practices overlap with one another and one cannot locate what is the pure ayurvedic way in each of these practices.

Lambert has indeed pointed out that there are domains of secular subaltern therapeutics that imagine the body differently from the views of the hegemonic biomedical model (Lambert 2012, 109-125). I extrapolate from this argument by stating that many therapeutic forms imagine the body differently to which ayurveda is indebted. I further argue that a rational and secularized ayurveda evolved as an indigenous knowledge amongst a set of practices of knowing that often interacted through give and take from each other and did not raise any claim of being at par with (modern) knowledge.

In 1959, the Travancore Ayurveda Patasala, introduced research on ‘Malabar special treatment’ which included massaging and bone setting (Mohanlal 2014, 98-99); two practices integral to kalari marmachikitsa. The research was intended
to integrate the Malabar special treatment into ayurveda, and the government sanctioned ten beds for this study. Later, in the last decade of the twentieth century, the term ‘Malabar treatment’ was abolished by introducing *Panchakarma* into the curriculum (Mohanlal 2014). Though bone setting was a part of *marmachikitsa*, it did not get any prominent place equivalent to vital spot massage that was incorporated into ayurveda as *Panchakarma*. Nevertheless, particular texts are not available in Sanskrit or vernacular languages that describe anything as Malabar special treatment. But most of the efficient *kalari* practitioners of the early twentieth century were experts in vital spot massaging and bone setting. They did not follow any textual tradition to learn the techniques, especially bone setting, which was integral to *kalari*. However, by the third quarter of the twentieth century, many books on *marma* were published. So, the regionally specific healing practices were selectively included into the seemingly textual tradition of the classical ayurvedic curriculum. Initially the selection was as ‘Malabar special treatment’ indicating the regional specificity of the practice, and later as Panchakarma by erasing the regional specificity.

Despite their internal diversity and specificity, diverse medical practices like *siddhavaidyam, vishavaidyam, marmachikitsa, ottamooli vaidyam,* etc. were either seen as part of classical ayurvedic practices or separated as folk practices with no scientific basis and not following the set rules of ayurveda completely. *Siddhavaidyam* and *ottamoolivaidyam* were labelled as esoteric because of the secrecies that shrouded their practice and medicinal preparations. In the

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50 Interview with Madhu Puduppanam, 27.11.10; Karunan Gurukkal, Vattoli, 30.05.10; Prasad Gurukkal, Valapattanam, 23.11.10; Choorakkodi Kunji Moossa, Villiapally, 27.11.10.

51 *Ottamoolis* are special medicines meant for particular diseases such as jaundice, kidney stones, piles etc. The secret of these medical preparations are not available in any of the publicly circulated texts. This is treated as a secret knowledge of a *vaidyan* or his/her family who prepares the medicines and passes this knowledge from generation to generation within the family. *Ottamooli* is also described as one-time medication or a single ingredient medicine.
nineteenth century, the department that dealt with such practices was named as Nattuvaidyasala Department in Travancore and Department of Indian System of Medicine (ISM) in Madras Presidency (Mohanlal 2014, The Usman Committee Report 1923). The differentiation between ayurveda and nattuvaidyam was negligible in that time. Also, it was not very important to identify something as ‘nattu’ or indigenous and something as ‘non-nattu’ or coming from outside/foreign. Later, in the 1950s, the department in Travancore was renamed as the Department of Indigenous System of Medicine and in the 1970s once again it was reformulated as Department of ISM (Mohanlal 2014). These changes of names suggest that a well-settled differentiation between ayurveda, siddha or nattuvaidyam was impossible and the state was conscious enough to select a broader title to include diverse practices such as yoga, unani, siddha and homeopathy. In the contemporary, the state classifies the above practices either under ayurveda or under siddha and within the overarching AYUSH department. The state took an ambivalent position towards nattuvaidyam as it was difficult to delegitimize them because of its interrelation and intra-relation with modern institutionalized ayurveda.

52 The Report of the Committee on the Indigenous System of Medicine, Madras, 1923