The Patient as a Knower: Principle and Practice in Siddha Medicine

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The relation between experience and knowledge has been the subject of several debates in the sociology of knowledge, especially with regard to medical knowledge. The disease is experienced by the patient and the physician, who has the knowledge of disease, conducts the diagnoses and provides treatment. This poses two questions: Does the patient, who experiences the disease, have knowledge? Does the physician, who knows the disease and its cure, have recourse to experience? How does epistemology address the relation between the ontology of the patient the layman and the doctor the specialist?

After a presentation of the problematic as it reveals itself in the analysis of biomedicine, the paper proceeds, based on fieldwork with siddha practitioners in Tamil Nadu, to examine the siddha medicine approach to these issues.

The relation between experience and knowledge has been central to discussions in the philosophy of science; various traditions of knowledge, western and eastern, have addressed this relation in some way or the other. The manner in which the relation between the sufferer’s experience and the medical knowledge of the expert is articulated is a core aspect of any system of medicine. How systems of medicine address the issue would be an interesting point of entry into the sociological study of medicine. This is not so much a question of epistemology, namely the theory of sources of knowledge; rather it pertains to foundational questions of ontology: What is the nature of the knowledge, who is the knower, what is known and what is the purpose of the knowledge.

1 Disease as Paraclinical Reality

In a laboratory-centred system of medicine such as biomedicine, the disease is gauged in terms of parameters that are comprehensible largely by the expert. The measurements given by diagnostic technology do not include the disease experience of the patient as a decisive factor in diagnosis. There is thus a hiatus, or the possibility of one, always built into the system of medicine between the physician’s definition and the patient’s experience of the same condition. In medical anthropology, the problems suffered by the person are referred to as “symptoms” and the doctor’s medical interpretation of the symptoms as “signs” (Hahn 1984). The gap between symptoms and signs has become pronounced in biomedicine ever since the medical equipment and laboratory technologies came to define diagnosis in terms of measurements of the diseased organ, function and process.

Advanced diagnostic technology identifies diseases as “abnormalities of structure and function at the cellular, biochemical or molecular level” (Helman 1985: 13). “With increasing frequency in modern medicine, diseases are diagnostically identified as abnormalities not in a patient’s clinical state (such as fever, jaundice or chest pain) but in a paraclinical entity” (Feinstein 1975 as cited in Helman 1985). The paraclinical entity emerges when the pathologies are plotted in the morphology of organs at minute levels as cellular structure, cross sections of biochemical or physiological functions. But greater precision in the measurement of the internal organs, even from the viewpoint of the doctor, entails a distance from the clinical manifestations of the condition. It also necessitates alienation from the manner in which the condition is actually experienced by the patient. “Although the aid of modern diagnostic technology allows these paraclinical abnormalities to be diagnosed with unprecedented specificity
and consistency, the principal ‘lesion’ of each such paraclinical disease has an associated spectrum of diverse clinical manifesta-
tions that may not always concur specifically or consistently” (Feinstein 1975: 4). Simply put, identical lesions in the organs may produce very different symptoms in different people.

1.1 The Patient in Biomedical Praxis

Substitution of technology to reduce subjectivity of judgment leads to the production of what Nandy and Visvanathan (1990: 153) call, “the shadow patient” as opposed to the real patient. The shadow patient is constructed through a set of numerical parameters of his/her morphology and physiology in a manner that could be controlled and manipulated by medication. The patient experiences the disease but this somatic awareness is marginal to the clinical process. Situations in which a person may not experience any discomfort but is regarded as diseased, as in the case of hypertension (Schoenberg and Drew 2002) are not uncommon. Inversely when a person suffers from an ailment such as chronic lower back pain, but there is no detectable muscular or bone lesion, the ailment/pain is regarded as illegitimate or as the imagi-
nation of the patient (Cooper 1999).

Two correlates of this episteme may be discerned at the level of the dyadic relation between the doctor and the patient and in the institutional procedure for payment. First, the diagnosis, decisions about treatment and its evaluation take place in the lan-
guage of experts. Clinical testing and manufacture of medicine is done by pharmaceutical laboratories and factories which are divorced from the patient. The language of numerical parameters of the shadow patient mediates these functionally and physically separate institutions in that the effect of drugs is noted in terms of the shadow patient. The doctor who dispenses the medicine is a small part of the huge, functionally differentiated network of institutions pertaining to biomedicine. As drug testing is done by other institutions under controlled laboratory conditions, the patient’s discomfort with medication or treatment is not a valid ground for doubting the effects of medication, unless there is maj-
or damage to a large number of patients in the same place. Thus, the patient is an object of biomedical knowledge; an educated patient is an informed object of knowledge. Phenomenology of biomedicine points out to the fact that the metaphor of the dead body which is the source of the anatomo-clinical knowledge is reproduced in the clinic where the patient is an “animated corpse” who yields to the physician’s manoeuvres (Leyder 1992).

Unlike homeopathy and the Indian system of medicines (ISMs), biomedicine does not have a theory of individualised body con-
stitution that helps understand the effect of medication. The suf-
ferrings on account of medication/treatment is attributed to indi-
vidual “variation” and transferred to the patient. Legal rights to sue for damages are available to an aggrieved patient after the damage has occurred, but only in terms of another expert who assesses the damage in technical terms. The patient’s experience, thus, has no status in a complex network of institutions premised on expert knowledge which give legal/moral rights to the patient but no epistemic role to cognise his/her body.²

Second, according to the normative framework of biomi-
cine, payment made by the patient is not for the efficacy of the
treatment/medication given. It is for the expertise of the physi-
cian, cost of the tests and equipment used irrespective of their utility in delivering relief to the patient. Hence full payment is mandatory whatever the outcome of the treatment and the pay-
ment is collected in advance of the session. If the patient is not satisfied, he/she may leave the doctor for another one, but has hardly any power to negotiate within the doctor-patient dyad to articulate dissatisfaction or uncertainty about the treatment by withholding payment.

1.2 The Disease-Illness Debate

These concerns are by no means new and have been articulated in medical anthropological literature for about 30 years since the 1970s. The anthropological critique of biomedical reductionism gave rise to the dichotomy between disease (objective fact based on lesions in the organic body that could be recorded) and illness (the behavioural and social response to disease) (Kleinman 1980; Good 1994). As the outcome of social science intervention in medicine, the disease-illness dichotomy was intended to show the inadequacy of the singular hegemonic explanatory model on disease, namely, that of the physician. The term illness was, therefore, designed to highlight the centrality of the patient’s experience of the disease condition.

Ambivalence in Cross-cultural Anthropology

In the 1970s, the disease-illness dichotomy, perceived within biomedicine was set up as a cross-cultural tool to facilitate the study of Asian systems of healing (Kleinman 1980). Kleinman explained that the Taiwanese healers worked on somatic manifes-
tations of mental stress through ritual, prayer, music and medi-
cine and were dealing with the illness, that is, patient’s subjective response to the mental disease. But he concluded that the healers left the mental disease untreated. Drawing on the findings about how Asian systems handled illness (though not disease), cross-
cultural psychiatry/anthropology impressed upon the medical fraternity to improve communication with the patient and to enhance the humane aspect of the medical system. Listening to the patient’s narratives then became an ethical imperative to augment the patient’s sense of well-being and help them cope with their subjective experience of illness (ibid) though the narratives may not have any centrality in the diagnostic process. Such interventions have certainly enhanced the patient’s right to good care though not necessarily his/her cognitive role in the clinical process.

Thus, the gap between body and mind in the biomedical framework is reproduced by the anthropologist as disease (objec-
tive reality of the body) and illness (subjective experience of the mind) in the disease-illness model. The model accepts disease as the objective, biological fact across societies and contradicts medical anthropology’s claim that all medical systems including biomedicine are social constructs. The debate on disease and ill-
ness reveals the crisis within medical anthropology that tries to mitigate problems of dualistic orientation of its object of study, namely biomedicine, while the dualism of the subject and object of knowledge is endemic to the world that social science inhabits along with biomedicine.
While this paper does not go beyond these constraints, it tries to examine the conditions of such a possibility. The paper asks the questions: How is the relation between knower and known articulated in siddha? What is the epistemic position of the sufferer/patient in this system of medicine? The paper focuses exclusively on traditional vaidyas of siddha medicine. References to siddha medical practice in this paper pertain to the practice of the traditional vaidyas in contemporary Tamil Nadu. The field study on which this paper is based was done in central and coastal Tamil Nadu during 2005-07.

2 Siddha Philosophy

Unlike ayurveda, which was primarily a system of medicine, siddha medicine was an offshoot of the siddha yogi’s experiments in yoga and alchemy towards the achievement of an uninterrupted lifespan and an imputescible body in this world. Siddha medicine is found only in south India and the texts are largely in Tamil and Telugu.

The siddhars were not a cult of a particular historical period, but heretics who challenged the religious orthodoxy in the Tamil region for several centuries till about 17th century AD. Most of the siddhars belonged to non-brahmin communities and were vociferous critiques of brahmanical Hinduism, the scriptures, idol worship and ritualism. The siddhars rejected both, the imbalance of the “unpurified emotionalism” of bhakti (Ganapathy 2004: xvi) as much as the scriptural philosophies of brahmanical Hinduism. A notable feature of siddha philosophy is the absence of any deity or personal god; but they were neither atheists nor agnostics. The siddhars were devoted to the attainment of the state of perfection or siddhi. They rejected the authority of the scriptures because mystical experiences being formless cannot be confined to any structure or convention.

Siddha literature is in Tamil verse form and some of them are in folk idiom or nirgrantha (non-textual) philosophy as they are called. The vulgar idioms used by the siddhas in their verses and their engagement in alchemical experiments earned them the fearful image as tricksters/tantrics. One also finds in the siddha corpus, abuse of women as forces that wean aspirant yogis from fearful image as tricksters/tantrics. One also finds in the siddha corpus, abuse of women as forces that wean aspirant yogis from

3 Cognition and Knowledge: Siddha Episteme

Our argument is that in the ISMs in general and in siddha in specific, the anomaly of a radical disjuncture between the patient’s experience and physician’s knowledge is unlikely. That is, a situation in which a patient’s discomfort is deemed illegitimate or psychological.imagined because there is no corresponding, measurable organic lesion in the body, will not occur in siddha medicine and the reasons for this coherence follows.

Self as the Knower

We start with the qualification that in the ISMs, especially in siddha, the concern is not so much experience versus knowledge, but cognition and knowledge. The valid bases of cognition, namely perception and inference, are available in principle to any knower. A brief enquiry into the founding principles of siddha will help appreciate how this is articulated in three levels: siddha philosophy, theory of the body and nature, and in the understanding of disease causation.

It would not be an exaggeration if we say that in siddha philosophy the human body acquired an importance that it had not attained before in the spiritual history of India. Siddha did not seem to view the body as dispensable compared to the imperishable soul inside, rather sought to preserve the material body which is the substratum of other strata of consciousness. Further, “According to the siddha, an adept’s experimental field is always himself and his body, which contained in itself an immortal essence” (Ganapathy 2004: 525). The approach is one where the adept acts in the world not as a participating, personal consciousness but as a witnessing consciousness, observing and testing one’s own bodily parameters in the process of yogic practice. The ability of the knower to perceive one’s own suffering, namely, svavedana pratakṣya (Kandaswamy 2000) is listed among the
different measures (alavai is the Tamil equivalent for measure in the siddha theory of validation) of valid knowledge of the Saiva philosophies that siddha drew from.

**Panchabhutas and Sensory Modes of Knowing**

As for medical theory, the theory of panchabhutas\(^6\) is the starting point of any text on the subject. As is well known, Indian systems of medicine regard all substances (dravyas) in the world as made up of the five bhutas which could be apprehended through the five sense organs – ear, skin, eye, tongue and nose. Functions such as hearing, feeling, seeing, tasting and smelling are basic to the process of knowledge. Through the senses, properties of substances and their actions are known.

At one level, all living beings have basic ability to cognise through their sense organs. Even plants know by sensing the bhutas in terms of light, moisture and direct their roots and stem accordingly. Animals are also able to sense data from their environment for their survival (Sathaye 1986). Humans ascertain the panchabhautic properties of substances by observing their colour, smell, taste, sound and feeling their effect on the body system.\(^7\) But sense organs or the equipment in themselves cannot know; they merely record environmental stimuli. The mind is responsible for connecting the sense organ to its object in order to discern the data and this is true of animals as well. According to the medical texts, “The knower in the living beings is endowed with the ability to know by sensing phenomena around them in order to protect oneself from dangers in their environment” (Sathaye 1986). Living beings are thus endowed with basic cognitive abilities to sense and interpret inputs from their habitat.

Organs in themselves do not experience any pain as they are inconscient (acit). Experience of pain or pleasure from the sensory inputs is by the self as a “knower”. The inputs from the gross elements of the body are integrated and interpreted by a subtle substrate, the non-material knower inside the corporeal body. Devoid of the knower, the anatomical or structural sense organs cannot achieve knowledge. The human knower is endowed with agakaruvigal (internal apparatus), namely, manam (thought), puthi (enquiry), aganchal (will) and arivu (intellect) are part of the first level of the 96 principles in siddha medicine (Uttamaroyan 1987).

The identification of the panchabhutas on the basis of their apprehension by the sensory apparatus of the knower sets a level playing ground. Any knower thus has the basic ability to sense, recognise and understand one’s own body. This analytical framework of siddha provides scope for knowing both by the patient and the physician; this is achieved by refinement of the external (sensory) and internal (mind and intellect) apparatus through discipline and systematic training. In this sense, the patient is also a knower and not merely an object of the physician’s investigation through diagnostic equipment. The knower/percipient and his/her faculties become the centre stage of the knowing process in which the physician’s expertise consists in drawing inferences for the process of knowledge. Through the senses, properties of substances and their actions are known.

According to padartha vignana which is the theoretical basis of siddha medicine, the body is constituted by gross and visible, as well as, subtle and unmanifest elements. The term “padartha” (substance) refers to all things which exist, can be cognised and named (Dwarakanath 1998). All objects of experience, the concrete and the abstract and not merely the material body are therefore “padarthas” and worthy of study. In the siddha view of things, an integrated knowledge of the body will have to take cognisance of both gross and the subtle in the body (Uttamaroyan 1983). These broad metaphysical principles form the basis for both, a science of substances and of the human mind.

The notion of disease in siddha medicine is a case to point. The texts say that “a change in the indications of the seven dhatus\(^8\) of the gross body produced by a dosha is experienced as disease by the knower” (Uttamaroyan 1983). Dosha is an alteration in various bodily parameters triggered by changes in metabolism, namely, the process of digestion and distribution of food essence to various dhatus (tissues), conditioned by a combination of gross factors like food and subtle factors like stress. Among other things, doshas could be ascertained by observation of bodily patterns and by examination of excrements. The entities of the body identified by siddha medicine as such doshas are not the organs themselves but their functions. The siddha conception of the body includes the mind by its very definition. The mind as the repository of thoughts and memories is a subtle substrate constituted by food and lifestyle as much as the other dhatus/bodily tissues (Obeyesekere 1977) and is subject to the tridosha principles.

**Siddha View of the Body**

In the siddha view, the body is more than an organ system and disease cannot be accounted for by the organs alone. Different substratums of the body are constituted on the basis of substances that nourish them, whether it is gross substances like food and water or, subtle substances like prana,\(^9\) thoughts/memories and intellect. The organ system, namely, of the seven dhatus nourished by food and water make the gross body or sthula udampu, only one among other substratum/sheaths.

There are four other sheaths nourished by subtle substances and hence part of the subtle body or suksma udampu. They are vali udampu (body of wind), the mana udampu (the body of mind/thoughts), ariv udampu (the body of the intellect) and inba udampu (the body of bliss). For instance, the vali udampu refers to functions governed by wind/vali, starting with orifices in the body through which wind enters and exits. It also includes the hollow channels inside the body that carry life sustaining prana and the organs of movement, namely, the limbs, together known as karmendriyas. A host of disorders pertaining to movement, functioning of the limbs and nervous system are attributed to the vali udampu. The vali udampu is the focal point of an entire (sub) system of medical machinations known as the varma chikitsa which by different kinds of touch and pressure stimulates the vital and nodal points in the physiology of wind and its channels that is different from the anatomy of the gross body (Uttamaroyan 1978, 1983, 1987).

A living body is thus central to siddha ontology because one can never study the flow of prana in a dead body that is devoid of...
prana. As discussed in Section 4, the elaborate naadi sastra and varma texts in siddha could not have emerged through dissection of dead bodies, but only by studying live bodies in situ. The idea of self as a knower makes the lived body the fulcrum of knowledge as opposed to anatomical knowledge from a corpse.

4 Confluence of the Subject and Object of Cognition

Broadly speaking, siddha shares its epistemology on sensory modes of knowing and the panchabhutatas with ayurveda. Siddha mysticism probably worked upon this conceptual base and perfected the significance of the subject of knowledge.

Physician as Knower and Consupjecitivity

Some of these principles may be found in operational conditions of siddha medical practice. Let us consider naadi pariksha (pulse-reading), which is a common diagnostic tool for several systems including ayurveda, Chinese medicine and allopathy in early times. In siddha medicine, the use of naadi is informed by the theory of panchamayakosa or five sheaths of the body. Daniel Valentine’s (1984) account gives us an idea of the three stages of naadi pariksha technique in siddha medical practice. In the first stage, the vaidya ascertains the nature of the vitiated doshas in the body of the patient through reading of the pulse. Here the attempt is to gauge the derailment in the solid, tangible tissues (dhatus) of the body in its gross sensory stage, sthula nilai. In the second stage of pulse reading which is the inner stage, namely, ul nilai, the physician becomes consciously aware of his own pulsations even while he is clutching the patient’s wrist. In the third stage the physician modulates the pace (natatai) and weight (etatai) of his own pulse that was inert to become concordant with the pulse of the patient. This stage is one of equipoise called cama nilai. Only after this stage of ‘shared’ pulsations does the vaidya write out the prescription. Daniel further explains how at the third stage of confluence of pulses, “the physician may be said to have experienced in some sense the suffering as well as the humoral imbalance of the patient. It is the knowledge derived from this experience that makes him return to his own symbolic tradition, the siddha body of knowledge, to find therein the appropriate remedy to prescribe” (ibid: 120). Pulse reading in siddha according to Valentine, neutralises the divide between physician and patient, starting with the objectivity of the sthula or material body and replacing it with consupjecitivity, even if only for a moment.

The ability to bring one’s pulse in confluence with that of the patient, however takes several years of training under a preceptor. It certainly requires great skill to attain cama nilai and may not be found with equal veracity in all instances. In the context of medical practice, caste and gender differences have hindered the use of pulse reading for all patients. But the mode of knowing it entails is institutionalised in siddha medicine. Vaidyas from various caste groups treating snake bites have often reported that reading their own pulse under various emotional states is a key element of their training so that they may distinguish loss of consciousness due to snake bite from dizziness due to fear of snakebite (Sujatha 2003). The physician as knower/subject of knowledge achieving shared pulsation with the patient is one dimension; the patient as a knower whose cognition has a role in diagnosis is the reverse of this in the dyadic structure of the vaidya and the patient. This does not mean that every practitioner of siddha is a yogi. But the yogi’s ontology has certainly had a key role in siddha medicine.

Operational Medical Texts

If we examine the siddha medical texts that are used by practising vaidyas, we find that they are compendium of diseases organised under a well defined system of classification. It is interesting to note that in many of the texts, the description of diseases is in terms of symptoms experienced by the sufferer/patient. Importantly, pains and aches are valid disease category in siddha: There are standard terms in the texts to denote kinds of pain in relation to their causes and tested methods of treating them. In the classification of diseases, subclasses often have as a prefix the kind of pain they produce.

The point here is that in these texts disease is first understood as it presents itself in the experience of the patient. The physician has to reckon with the symptoms as described by the patient, in other words, data of the actual experience of disease is an essential component in the diagnosis. Within a given taxonomy of disease, the vaidya’s compendiums provide a symptomatic description of each condition in verse form, which the vaidyas commit to memory during their training. In some sense this may be seen as objectification of the subjective by codifying and memorising.

Our study of certain Tamil medical compendiums in siddha and ayurveda shows that though the texts were in verse form, their structure, language and content were not divorced from common parlance by complicated jargon. Most importantly, the texts were not necessarily addressed to the expert. For instance in a text of 1890 called Bala Vagata Thirattu, the description of diseases of children is done symptomatically; the symptoms indicated for a condition known as slethuma mantham in the texts also includes behavioural symptoms of the infant as understood by the adult, such as twisting of legs and the tendency to avoid being held in the adults’ arms. These are also part of the clinical diagnostic criteria of the vaidya. The villagers in the area also described the disease in terms of the same behavioural and physiological symptoms.

We have to caution that while the symptom as experienced by the patient is the starting point of the diagnosis, it is not the diagnosis itself. Professional expertise is required to further interpret the symptoms and arrive at the therapeutic procedures. Technical texts comprehensible exclusively by a professional are very much part of the vaidya’s training. So the point is not that diagnosis, interpretation and treatment are common-sensical or completely comprehensible by the patient at every stage. Siddha medical knowledge could be highly technical and exclusive. We just saw how pulse reading that is the subject of several texts on naadi sastra entails rigorous training and skill. Our point is that in the context of the dyadic structure of the vaidya and patient, the possibility of a gap between patient’s cognition and vaidyas’ knowledge is eliminated by making the patient’s cognition the starting point of the diagnosis.

The centrality of the patient as a knower is reflected in the fact that the process of cure not only begins, but also ends in his/her
terms. That is, after treatment, the test of its efficacy is that the symptoms that the patient started with have to disappear and the patient should be able to cognise the relief. While it may be true of any system of medicine and a patient could leave a doctor when the cure is not satisfactory, the question is about institutional means to express the dissatisfaction. In siddha vaidya's practice, as in most SMSs, if the patient is not convinced about the efficacy of the treatment, he/she will not pay for it. Professional expertise is accountable to the patient in several ways and accountability is built into the norms of the siddha medical institutions as explained in Section 5.

5 The Patient as Agent of Therapeutic Validation

Diagnosis as Commitment

First, let us examine the process of diagnosis. When the patient arrives and narrates his/her symptoms, the first and essential step required on the part of the vaidya is to say whether the disease is curable or not. This is indeed a crucial aspect of siddha in a fundamental way because even the texts begin with the primary distinction between diseases that are curable and those that are incurable as per the expertise available in the text. The texts also describe the symptoms of incurable disease and make it known whether they are fatal or could be managed. The texts instruct the vaidya to declare whether the condition is curable or merely manageable.

In addition to saying whether the disease is curable, the vaidya also has to say how far the medicine will cure. In fact the vaidya who treats eye diseases says that when he treats what we call cataract, he has to make a statement as to how many years the intervention will be effective. The age of the patient and stage of the disease are key factors in this decision. Though the vaidya starts with the symptoms presented by the patient, his credibility depends on his ability to make independent observations about how old the problem is, whether it has already been treated and to describe the other bodily variations associated with this condition.

Almost all the vaidyas say that they have to make a statement of commitment to the patient or his/her relative as to how long it will take to cure the disease and how far it can be cured. In case the vaidya fails to cure the disease within the said period, or if the patient is not fully relieved of the symptoms, then the patient has the right not to pay. Often the patients withhold part of the payment until they are satisfied that the symptoms have disappeared. Vaidyas regard with awe how in the clinic, the doctor extracts payment even without a diagnosis, leave alone cure, because for them diagnosis is some kind of a commitment to cure. As an example of unethical practice, the vaidyas often point to private practice under the clinic system in which the patient has to pay the full amount even if the treatment were not effective.

Payment as Therapeutic Validation

Payment modalities are indeed connected to the perception of the vaidyas role in society. Generally, part-time village vaidyas who treat one or two simple diseases cannot demand payment. They would have acquired this knowledge and the right to provide treatment as members of a tradition and a token offering is to be made to the vaidya's family deity. In case of remedies picked up on one's own, payment may be made but only as per the discretion of the patient. Professional vaidyas have to subsidise heavily for patients in their native or resident town. Generally there is no fixed amount for treatment; when a vaidya quotes an amount it is always open to negotiation. In principle, the cost of the treatment is the cost of the medicine; any vaidya, professional or non-professional, cannot charge fee for services from the patient. Earlier, vaidyas in a region received grants from patrons or grain payment from village produce for his services and so individual patients within the command area need not pay. Even after these grants and annual village payments have stopped, there is not much change in that the vaidyas get paid only for medicines.

The sources of livelihood for a full-time vaidya then is outstation patients who approach him/her on hearsay or the vaidya's own visits outside the area because he/she is bound by an ethical code against demanding payment from fellow villagers. In general, the payment for the treatment increases with distance of the patients' hometown and his/her anonymity. A smart outsider is however likely to get a kinsman in the neighbourhood of the vaidya to accompany him. Further the payment is not generally done in full until the patient believes that he/she is cured. It is made in instalments such that the patient may suspend balance payment in case of dissatisfaction. So the vaidya has to assess whether the patient is likely to pay up properly before making costly preparations because the patient may chose not to pay if not satisfied.

Uncertainty about the cost of treatment compounded by the fact that the vaidya is a familiar figure in the village lead to certain downsizing of the vaidya's achievements even when it involves considerable skill. The local patient is also likely to be familiar with some herbs used in medicinal preparations and would therefore not consider the medicine to be valuable. The number of outstation patients visiting the vaidya is regarded a measure of professional competence and fame. In terms of financial liability, the clinical encounter is always tilted in favour of the patient.

The siddha vaidyas today are in a situation in which the socio-economic institutions and norms that supported their practice are undergoing transformation. While their practice continues to receive patronage from traditional benefactors and regular clients, the vaidyas have also changed with the times: They have increased their charges for medicine, changed the form of medicines, and accept all kinds of patients without avoiding members of depressed castes. Siddha vaidyas, especially those who treat sexually transmitted diseases do advertise in the newspapers, undertake periodical tours to various towns, consult patients in hotel rooms and collect fees in advance. While no systematic study of the efficacy of such treatments seems to have been undertaken, it is interesting to note that they are centred on the patient's experience and performance before and after treatment.

Collecting money in advance of curing the patient is regarded as a transgression by the old fashioned vaidyas and the norm cannot be violated in the vaidya's hometown at least. A siddha vaidya explained that for treating bites of venomous creatures and performing the mantra (chants), the vaidya has to be a nishkamik (to be without desire). That is, he/she cannot employ the knowledge for monetary gain because it is intended to be a prestigious service to
the “ur” (village community) bestowed by the family tradition. Another visha vaidya put it thus, “this is our karma thoasil (ordained profession); we cannot demand payment. I have asked my brothers and children to stay out of it because it is demanding.”

6 Conclusions
The position of the patient as a knower and the apprehension of disease in terms of symptoms cognised by the patient may have freed the dyadic relation between physician and the patient in siddha medicine from the anomalies of epistemic asymmetry. But this is not all. The question is what the ramifications of this epistemic feature are for the patient? Uncertainty and ineffectiveness may be experienced in any system of medicine. We need to examine if the process calls for any agency on the part of the patient as a knower and whether the patient could thereby have an understanding and control over the situation.

Biomedicine inhabits an institutional framework in which the doctor-patient dyad is embedded in a complex web of organisations such as the pharmaceutical and medical equipment industry, research laboratories and hospital administration. Structural and functional differentiation, as it is called in social science theory, is considered as an indicator of growing complexity and progress. An enormous amount of specialised knowledge is generated in each of these structures by several interest groups with varying purposes. The deployment of knowledge for therapeutic purposes is hence conditioned by processes extraneous to the clinical process. In this complex mesh of expert knowledge, the patient as a “lay” person is only an object of capital and technology mediated knowledge. The weak position of the patient as a lay person in relation to the expert is a function of the strong institutional links between professionals. Structural differentiation, no doubt a complex solution, lacks sophistication in terms of the connection between the technologies of generating medical knowledge (in the Foucaultian sense) and the purpose of medicine, which is to reckon with suffering in terms of the patient’s cognition and provide relief from it.

A normative framework as in siddha which places emphasis on the patient as a knower, does give him/her greater hold over the therapeutic process. This has put in place an arrangement in which medical knowledge is committed to the primal purpose of medicine as a social institution. But the primacy of the physician-patient dyad is likely to constrain the growth of strong professional ties among the vaidyas. As an approach to the problem of health and disease, this arrangement is not complex for it integrates several functions including medicinal preparation within the dyad. But it is sophisticated in that it ensures that institutions are oriented to their manifest purpose, or dharma, as the vaidyas put it, in this case relieving the suffering of an ailing person without demanding remuneration. Sophistication may also be discerned in the episteme according to which every subject or substance has its own dharma which the process of knowing cannot violate.

There is no attempt here to exclude complexity in favour of sophistication, rather the argument is that they have coexisted and would continue to do so though in different forms. Notwithstanding

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the magnitude of changes that the Tamil region has undergone, very different approaches have managed to thrive in spaces outside the state and the market. They are not vestiges of any pristine past but have changed along with the social profile of their protagonists. Siddha medicine today is by no means identical to the viewpoint of the early siddhars; nevertheless, we find principles of siddha ontology in their contemporary institutions. The dichotomy of tradition and modernity is of little use in explaining the contemporaneity of siddha medical institutions and the complicated dialectics of philosophy, medicine and society.

REFERENCES


Good, Byron (1904): Medicine, Rationality and Experience (Cambridge: Cambridge University Press).


NOTES

1. The distinction between signs and symptoms in siddha medicine has its roots in Foucault’s characterization in Birth of the Clinic. “The symptom... is the form in which disease is presented, the first transcription of the inaccessible nature of the disease. The disease is never exposed to the senses but only its pathological manifestation namely the symptoms” (Foucault 2003: 110). In anatomoclinical perception, “the sign is an informed medical reading that has lately come to silence the symptoms” (ibid: 196).

2. Even the critique of the domination of expert knowledge, such as Habermas on the “Colonisation of the lifeworld by the system” only grants moral right to the individual to “communicate” or voice his/her discomfort and seek redressal but not any clinical process. For details see Jurgen Habermas (1984; 1990).

3. Traditional vaidyas here refers to those vaidyas who have been trained in the profession under guru-shishya parampara for at least five to seven years and have officialised their training under the supervision of the body nourished by food. They are, gold, silver, copper and farm labour, when they adopted the path of siddhi. Two siddhars, namely, Karuvurar and Ramadevar are said to have been brahmins (Ganapathy 2004).

4. Ongoing research into siddhars’ biography indicates that most of those who were engaged in occupations like goat rearing, snake charming, goldsmiths, copper and farm labour, when they adopted the path of siddhi. Two siddhars, namely, Karuvurar and Ramadevar are said to have been brahmins (Ganapathy 2004).

5. Sociology of knowledge and anthropology of medical knowledge arising from enlightenment philosophies and phenomenology pose the problem as experience versus knowledge; hence in the use and analysis, lived experience as a sense organ is a lesser entity than knowledge that comes from reflection.

6. Panchabhutas are prithvi, ap, tejas, vayu and akasha in Sanskrit; mann, neer, ashal, veli, vali in Tamil. Panchabhatas are water, fire, wind and ether in English. The bhutas are principles of matter apprehensible by the five sensory organs.

7. Humans augment their sensory apparatus by using equipment that serve as extensions of the sense organs, for example, the microscope, that serves to broaden the basis of the datum that flow through the senses.

8. Seven dhatus are seven material/gross constituents of the body nourished by food. They are, rasa (plasma), rakta (blood), mamsa (muscle), medas (fat), emba (bone), moaul (brain) and sukra (semen).

9. Prunan as it is called in siddha is wind/vali/vayu which circulates through hollow channels in the body and sustains breath that is fundamental to life.

10. Sthula is the next outermost sheath/layer to suksma or subtle body.

11. In an episode during my fieldwork in coastal Tamil and in 2003, a person didha collegue demanded that his daughter’s naadi be examined properly and the vaidya agreed because the patient had a good record of payment.

12. We are using the term operational medical texts here to refer to the texts used by siddha vaidyas in clinical practice, in order to distinguish them from general siddha texts that deal with mysticism and medical theology together. There are different kinds of siddha medical texts; those probably written by the original siddhas and those authored by professional siddha vaidyas. In this section we are examining the latter.

13. One of the key issues in the disease-illness dichotomy is the status of pain, whether it is a disease or response to the patient. However, biomedicine’s pain that is not matched by evidence from x ray or orthopaedic diagnosis is considered illegitimate”. Pain killers are given but the treatment may end there.

14. There are several references that point to the significance of patient’s testimony in early modern European medicine that was also patient-centric.

15. We are not saying that accountability to the patient is an unmixed virtue. It could lead, as it often has, to an undervaluation of the vaidyas’ expertise and downsizing of his professional role.

16. We saw how compendiums and operational texts learnt by the vaidya describe diseases in terms of symptoms. Vaidyas that mention his ailments to the vaidya, he/she may not state all the symptoms experienced. On hearing part of the symptoms, the vaidya will have to identify the others based on his learning: such a vaidya is highly regarded by the people. Hence at the level of practice we may not always find lengthy narration of symptoms by the patient, though in general the patient has considerable leeway to discuss his/her symptoms and to be heard (Trawick 1987; Obeyesekere 1993).

17. In certain instances where the vaidya is aware that the patient’s condition is very serious, he may decline to treat the patient and refer to the hospital because death of a patient in the vaidya’s premises would bring bad reputation. Besides in the event of death of the patient during treatment, there is a likelihood of the vaidya being beaten up by the aggrieved members of the patient’s family whereas such aggression is unlikely in the case of a hospital.

18. When the patient mentions his ailment he/she symptoms and to be heard (Travik 1987; Obeyesekere 1993).

19. Histories of professionalisation of medical practice in Europe and America (see Starr 1983 for instance) point out how the erasure of popular health traditions, formalisation of medical education and the creation of a professional association of practitioners have been instrumental to the growth of a powerful scientific community.