HEALTH CARE IN INDIAN BUDDHISM

HEALTH CARE IN INDIAN BUDDHISM: REPRESENTATIONS OF MONKS AND MEDICINE IN INDIAN MONASTIC LAW CODES

By JESSICA FISH, B.A.

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ABSTRACT

In this Master's thesis, I attempt to illuminate the historical relationship between Classical Indian medical practice and Buddhist monastic law codes, vinaya, in India around the turn of the Common Era. Popular scholarly conceptions of this relationship contend that the adoption of the Indian medical tradition into the Buddhist monastic institution is directly traceable to the Pāli canon. The *Mūlasarvastivāda-vinaya* (MSV) does not appear to take issue with physicians or medical knowledge, yet the condemnation of physicians in ancient Indian literature strongly suggests that the relationship between monks and medicine is more complex than the Pāli canon illustrates. Similar to other *vinaya* traditions, the MSV includes detailed information about permitted medicaments, as well as allowances for monastics to provide medical care to other monastics and even, in particular cases, the laity. I argue that the incentives for monastics to maintain a positive relationship with the medical world were driven by the economic benefits of monastic medical knowledge, as well as associations with wealthy physicians. Using a variety of extant Sanskrit materials, as well as epigraphic evidence, I aim to present a nuanced picture of the history of the relationship between Indian Buddhist monasticism and medicine around the turn of the Common Era.

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Introduction

In this thesis, I seek to illuminate the historical relationship between Indian Buddhist monasticism and medicine around the turn of the Common Era. I bring to light how the rise and spread of Buddhist monasticism was influenced by the preexisting medical traditions, as well as social and religious norms that denigrated both medicine and medical practice. Central to my discussion are the ways in which Indian Buddhist law codes, *vinaya*, reflect an early monastic concern to uphold a positive public image in Indian society. Due to the monastic reliance on lay members for the procurement of food and other donations, the economic security of the sangha was dependent on maintaining a positive relationship with the laity. As such, the daily lives of Indian Buddhist monks and nuns were necessarily guided to uphold this relationship. Underlying my thesis is the argument that the relationship between monks and medicine in early Indian monasticism was largely motivated by the economic benefits associated with the provision of medical care. For example, extant monastic law codes such as the *Mūlasarvāstivāda-vinaya* (MSV) include regulations pertaining to monastic interactions with medicine and medical practices, and record allowances for the provision of medical care to not only sick brethren, but also wealthy laity.

Monasticism and Medicine Through Rose-Coloured Glasses

To date, our major source of knowledge about Indian Buddhist monasticism in general, and its relationship with medicine in particular, has been the Theravādin *vinaya* of the Pāli canon. However, in recent decades, scholars have called into question the utility of

the Pāli canon for the study of India, based on the fact that it was redacted not in India, but Sri Lanka. Inconsistent evidence contained in extant Sanskrit materials has made evident the limits of using the Pāli canon to shape and transmit a comprehensive, nuanced history of Indian Buddhist monasticism to contemporary audiences. By looking instead to Sanskrit texts such as the MSV, as well as the Indian epigraphical record, we have been forced to re-evaluate what we thought we knew about the daily life of the Indian Buddhist monk.

The relationship between Buddhism and medicine is complex, and inextricably tied to the relationship between Indian society and the social, political, and religious norms that shaped the ancient Indian worldview. Scholarly approaches to the study of Indian monasticism and medicine that rely only on Pāli sources obscure contemporary understandings of both monasticism, and the Indian medical tradition. Scholars such as Gregory Schopen and Shayne Clarke have convincingly traced romanticized conceptions of Indian monasticism back to the scholarly reliance on the Pāli canon. As Clarke explains:

> Modern Western understandings of Indian Buddhist monasticisms seem to have been based largely on two sets of images: (1) European notions of medieval Christian monasticism and (2) visions of the ideal monk from within modern, particularly Theravāda, Buddhist traditions and their canonical texts… . When early scholars looked at canonical Buddhist literature with certain preconceptions about the monastic life, the images of "monks" and "nuns" that they saw largely confirmed their assumptions. Yet what they accepted as representative of

> Buddhist monasticisms was, I suggest, highly romanticized and rhetorically charged.[1]

In his book, Clarke demonstrates how romanticized approaches to the study of Indian Buddhist monasticism oversimplify understandings of the way that Buddhism engaged with family affairs, particularly since contemporary scholars tend to conflate what is written in the Pāli canon with the historical actions of Buddhists in ancient India.

In his collection of papers in *Buddhist Monks and Business Matters*, Schopen demonstrates the importance of characterizing the life of the Indian Buddhist monk through extant Sanskrit sources such as the MSV.[2] Using a number of MSV narratives, Schopen explores how the earliest members of the Buddhist sangha may have dealt with issues such as debt, funerals, inheritance, and property.[3] In *Managing Monks*, Jonathan Silk discusses the roles and duties associated with monastic offices, such as those of the distributors of goods and assigners of monastic cells.[4] Indeed, to restrict our understanding of Indian monasticism to the Pāli canon is also to risk neglecting the diverse aspects that make up the monastic vocation.

Just as understandings of Indian Buddhist monasticisms are represented by an overreliance on the Pāli canon, popular conceptions of the development of medicine, particularly Āyurvedic medicine, and religion in India are subjected to similar

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[1] Clarke 2014: 2–3.
[2] Schopen 2004b.
[3] Ibid. For discussions of funerals and property, see "Deaths, Funerals, and the Division of Property in a Monastic Code," pp. 91–121; for debt and inheritance, see "Dead Monks and Bad Debts: Some Provisions of a Buddhist Monastic Inheritance Law," pp. 122–169.
[4] Silk 2008. For Silk's discussion of monastic duties, see "Vārika and Specialization of Duties," pp. 101–126. For a list of specific administrative responsibilities, see pp. 102–103.

romanticizations. Studies of Indian Buddhist conceptions of health and medicine are typically explored with the underlying assumption that codified medical information in the Pāli *vinaya* is an extension of Āyurvedic thought. Studies of the history of medicine in India tend to ignore the relationship between Buddhism and medicine, a type of romanticization that is not limited to the study of Buddhism and Indian medicine, but also Buddhism and other East Asian medical traditions.

Paul Unschuld, an expert in the history of ancient Chinese medicine, outlines three avenues through which ancient approaches to health care are portrayed in Western literature. The first is a romanticized view of Asian medicine as "preferable alternatives to orthodox Western medicine"[5]; the second is the selection of specific aspects of Asian medicine that align with Western biomedicine; and the third is comparative studies of the experience of the patient treated with Asian medicine versus Western biomedicine.[6] Unschuld explains the implications of this kind of romanticization, noting,

> Such an approach is both ahistorical and selective. It focuses on but one of the many distinctly conceptualized systems of therapy … and neglects both the changing interpretations of basic paradigms offered by [historical] authors through the ages and the synchronic plurality of differing opinions and ideas that existed for twenty centuries concerning even fundamental aspects of [these] therapy system[s].[7]

[5] Unschuld 2010: 2.
[6] Ibid. 2–3.
[7] Ibid.

Indeed, alternative forms of medical care such as Āyurvedic medicine have become increasingly commercialized in the West, influencing popular understandings of medicine and religion in India. Unschuld's criticism of the selectivity of Western scholarship associated with this portrayal of Asian medicine can be traced back to the conflation of medical histories with religious histories, and presented as unified systems of thought.

Working against these assumptions, Schopen demonstrates how religious ideology shapes the ways in which health was conceptualized and medicine was practiced in Indian Buddhist history. Schopen draws on the *vinaya* tradition of the Mūlasarvāstivādin School, paying particular attention to the economic incentives of early Indian Buddhists to adopt and codify Indian medical practices. Schopen refers to medicine as a strategic "financial instrument" employed by the sangha to use monastic facilities and knowledge of basic medicines to care for the sick and dying, often with the understanding that some type of financial transaction would take place.[8] Because Brahmanical ideas about the impurity of physicians left a gap in Indian society for the provision of medical treatment to the public, Schopen argues that the Buddhist sangha exploited the opportunity for financial gains. Thus, Schopen presents Buddhist lawyers as a active agents in the use of medicine as a financial technology.

To complicate further the issues illuminated by Schopen, scholarly attempts to present information about a coherent "Indian Buddhist medical tradition" are often conducted through the conflation of different Buddhisms and a range of medical

[8] Schopen 1995: 473–474.

traditions. For example, in order to illustrate his contention of a shared origin for Buddhist medicine and *Āyurveda*, Kenneth Zysk describes the similarities between Buddhist and Āyurvedic approaches to the treatment of skin conditions: he compares the medicines listed in the Pāli *vinaya*, orally transmitted during the first century BCE,[9] with the compendia of Caraka and Suśruta, compiled around the third century BCE,[10] and Buddhaghosa's commentary on the *Vinayapiṭaka*, dated to the fifth century CE.[11] Zysk writes that the medicines listed in the Pāli *vinaya* are an example of,

> The Buddhist delineation of certain foods as medicines [which] marks an early phase in the historical evolution of Indian materia medica. A similar classification of the medicinal foods found in the early medical compendia suggests a common pharmaceutical tradition.[12]

However, in attempting to classify a Buddhist medical tradition that is characteristically unique from the Āyurvedic tradition, Zysk's application of textual support (or lack thereof) ultimately works against his own argument. Hinging on Buddhaghosa's work, Zysk notes that "continuities in medical doctrine and practice" are more likely attributed to the temporal and societal connection between the *Samantapāsādikā* and the medical treatises of Caraka and Suśruta. However, the centuries between these works are significant; Āyurvedic medicine was well integrated in Indian society by the time the content of the Pāli *Vinayapiṭaka* was being transmitted, and developments in the Indian

[9] Von Hinüber 2004, 2: 626.
[10] Wujastyk 1998: 4, 61.
[11] Von Hinüber 2004, 2: 627.
[12] Zysk 1991: 83.

medical tradition in the nearly 800 years that passed before the redaction of the *Samantapāsādikā* cannot be ignored.[13]

Romanticized conceptions of Indian Buddhist monasticism and the Indian medical tradition convey a picture of the relationship between monks and medicine that does not hold when early Indian works, such as the MSV, are added into the scholarly discussion. Inconsistent information contained in extant Sanskrit sources such as the MSV and inscriptional evidence suggests that an overreliance on the Pāli *vinaya* may in fact result in an oversimplified picture of the complex interactions between monks and medicine in India. Thus, this thesis works to demonstrate that in order to present a comprehensive history of Buddhism and medicine in ancient India, both the monastic institution and the Indian medical world should be evaluated through the reading of MSV literature, as well as the Indian epigraphical record.

In *Asceticism and Healing in Ancient India*,[14] Zysk traces the development of medical thought alongside the ascetic, and later Buddhist, traditions in India from the sixth century BCE, onwards. He argues that the history of medicine in India is not rooted in Brahmanic orthodoxy, as earlier scholars contend, but in the melding of wandering ascetics, learned in medicine, with the earliest members of the Buddhist community (the sangha). Zysk's work has been highly influential for the understanding of Buddhism and

[13] In Zysk's (1991: 93–95) discussion of "Wind in the Limbs," he acknowledges the problems associated with the sources upon which his argument relies. On p. 95 he writes, "By Buddhaghosa's time (fifth century CE), however, knowledge of sudations was widespread in Buddhist circles. It is likely that most of [Buddhaghosa's] information about this form of treatment derives from the *Suśruta-saṃhitā*, which by that time probably existed in its extant form.

[14] Herein referred to as *Asceticism and Healing*.

medicine in India, since his monograph calls for the further study of not only the Indian medical tradition, but also specifically an Indian Buddhist medical tradition. Accordingly, Zysk categorizes the history of medicine in India as an evolution from magico-religious healing in the early Vedic period to empirico-rational medicine in the late Vedic period.

However, in his analysis of how Indian medical knowledge came to be assimilated into early Buddhist communities, Zysk privileges the Pāli *vinaya* as the authoritative source for information pertaining to monastic laws. He posits that the Four Noble Truths of Buddhism are based on a medical paradigm, "whereby suffering, its cause, its suppression, and the method for its elimination correspond in medicine to disease, its cause, health, and the remedy."[15] That is, Zysk argues that because the basic tenets of Buddhism were suited to fit already established medical ideology, medicine flourished within the sangha, and monks took on the role of physicians. Yet sources such as the MSV indicate a number of reasons, pragmatic and strategic, for early monastic groups to incorporate the use of medicine into their earliest law codes. My argument that economic incentives played an instrumental role in the relationship between monasticism and medicine in early Indian Buddhist history thus challenges the historical picture painted by Zysk.

[15] Zysk 1991: 38.

Summary of Chapters

This thesis consists of three chapters. My first chapter introduces Zysk's seminal work, *Asceticism and Healing*, as an example of contemporary Western scholarship that upholds romanticized notions of monasticism and medicine in early Indian Buddhist history by privileging the Pāli *vinaya* for his study of medicine in Indian Buddhist monasticism. This chapter is divided into three sections. In the first section, I demonstrate how ideas of the Middle Way result in romanticized readings of Pāli Buddhist literature. In the second, I consider what we do learn about the relationship between monasticism and medicine based on the Pāli canon, demonstrating inconsistencies in Zysk's use of the Pāli *vinaya* as evidence; and in the third section, I argue that regulations for the provision of medical care are more nuanced than Zysk describes in *Asceticism and Healing*, as loopholes are made in both the Pāli *vinaya* and the MSV, particularly if the sangha can benefit economically.

Overall, my first chapter demonstrates that the medical content of the Pāli *Vinayapiṭaka* cannot serve as evidence for the codification of a distinctly Buddhist medical tradition, as Zysk suggests. On the basis of evidence found in both the Pāli *vinaya*, as well as extant Sanskrit sources such as the *Mūlasarvāstivāda-vinaya*, I contend that the healing vocation of monks is codified such that allowances for the provision of care by monks were established to help ensure the economic security of the monastic institution. For example, the MSV suggests that healing services carried with them economic benefits: monks who care for one another, or even the laity, are legally entitled to inherit the sick individual's belongings, should the patient pass away.

My second chapter begins with a discussion of the condemnation of physicians in ancient Indian literature. Since *Dharmasūtra* and *Dharmaśāstra* literature strongly suggests that the medical vocation was not highly regarded by the religious and political elite of Indian society, I consider how the authors/redactors of the MSV reflect an early concern for the social and religious denigration of physicians. This chapter is divided into two sections. In the first section, I explain how medicine and medical practice are negatively framed in *Dharmaśāstra* and *Dharmasūtra* law codes, thereby affecting the status of the physician in early Indian society. In the second section, I argue that the MSV account of the biography of Jīvaka represents one such way that the authors/redactors of the MSV were able to reconcile the Brahmanical rejection of physicians with the economic benefits that health care afforded the monastic community.

In my second chapter, I contend that the MSV shows an early Buddhist effort to reconcile the social denigration of physicians with the economic utility of medicine for the Buddhist sangha. That is, as the result of the rejection of physicians in *Dharmasūtra* and *Dharmaśāstra* literature, early Indian Buddhists were more concerned with distinguishing themselves from the practices of worldly physicians, rather than rejecting the practice of medicine, proper. Indeed, *Dharmaśāstra* and *Dharmasūtra* materials justify this concern, particularly as they caution citizens against giving food to physicians.

My third and final chapter consults the epigraphic record of Indian Buddhist inscriptions in order to uncover archaeological evidence that illuminates further how the relationship between monastics and the medical world may have been driven by

economic transactions between monks and the laity. This chapter is divided into three sections. In the first section, I demonstrate how romanticized ideas of monasticism and medicine in early Indian Buddhist history influences the ways in which Western scholars interpret and understand the Indian epigraphical record, particularly through scholarly conceptions of monastic hospitals. In the second section, I read a selection of inscriptions that make references to aspects of the medical world against MSV sources in order to illuminate new ways of understanding them. In the third section, I employ a lesser-referenced category of inscriptions in studies of monasticism and medicine, donative inscriptions recording the names of lay physicians, as evidence for the economic relationship forged by the monastic institution with the medical world.

In sum, my third chapter uses the inscriptional record to argue that while there may be precedents to suggest that medical care did take place in early monasteries, the assumption that monks used these facilities to provide care to the population at large is, at best, speculative. By looking specifically at donative inscriptions that record the names of lay physicians, I posit that rather than arguing that monks provided care to the greater population, there are stronger grounds to consider that monastics instead drew on the support of lay physicians.

Overall, this thesis fits into a larger discussion of how Western scholars approach the historical study of ancient religions and medical traditions. Popular conceptions of health, medicine and religion, romanticized by understandings that privilege Pāli sources, are but one example of the ways in which the diverse medical histories of India are oversimplified in Western scholarship. In light of these criticisms, increasing reliance on

the Pāli canon as central evidentiary support for the historical integration of medicine into monastic practice is too narrow a scope, given the availability of other Sanskrit sources.

Chapter One

A Picture of Health in *Vinaya* Literature

Predating the redaction of the earliest known Āyurvedic medical treatises, Indian medical knowledge can be found in the religious literature of ancient Brahmanical and Buddhist groups. In *Asceticism and Healing*, Zysk writes that as early as 800 BCE, Indian medical practitioners were rejected by the dominant Brahmanic tradition and marginalized to the fringes of society. By the 6th century BCE, alongside other ascetic renunciants, Zysk contends that medical knowledge became dispersed amongst this new group of heterodox ascetics.[16] Zysk concludes that it was these heterodox ascetics who became the first members of the Buddhist sangha, eventually codifying their medical knowledge into the earliest Buddhist doctrines, the Pāli canon.

With regards to the Pāli *Vinayapiṭaka*, Zysk posits two theories regarding the development of Indian medicine within Buddhist monasticism:

1) The use of medicine by monks was "ideally suited to the philosophy of the Middle Way"[17] and thus was readily adopted by early Buddhist monastics, and codified in the Pāli *vinaya*.
2) By the mid-third century BCE, monk-healers provided medical care to the population at large, providing a means for the spread and dissemination of Buddhism throughout the Indian subcontinent.[18]

[16] Zysk 1991: 38.
[17] Ibid. 93.
[18] Ibid. 43–44.

In tracing attitudes towards medical practitioners from their rejection by the dominant Brahmanic tradition to their acceptance in the developing Buddhist tradition, Zysk paints a picture through 800–100 BCE of the transition from the magico-religious healing of the early Vedic tradition into the empirico-rational frameworks of medical writers. However, his assessment of the relationship between Buddhism and medicine in early Indian history rests on the assumption that the Pāli canon is historically representative of early Buddhist monasticism.

While Zysk's monograph is important for the study of religion and medicine in India in general, his characterization of the relationship between Buddhism and Indian medicine based on Pāli sources reinforces romanticized scholarly conceptions of a monk-healer ideal. In this chapter, I consider the argument of *Asceticism and Healing*, looking specifically at the medical content of the Pāli *Vinayapiṭaka*. In order to undertake a systematic evaluation of Zysk's arguments against the primary sources upon which his own arguments rest, I first explore what discussions of medicine, medical treatment, and sick monks in the Pāli *Vinaya* tell us about the relationship between medicine and Buddhism – an investigation that demonstrates further incongruences with Zysk's arguments. On the basis of a careful reading of I.B. Horner's *Book of the Discipline*, an English translation of the Pāli *Vinayapiṭaka*, I demonstrate how Zysk's illustration of the Buddhist medical tradition promotes romanticized assumptions about the daily life of the Indian Buddhist monk in early Indian history.

By looking at sources outside of the Pāli *vinaya*, this chapter will then draw on Sanskrit *vinaya* materials in an attempt to assess and illuminate further the relationship

between medicine and monasticism in early Indian Buddhist history. I argue that scholarly conceptions of a coherent Buddhist medical tradition informed by the Pāli canon must be reevaluated, based on incongruences between the MSV and the Pāli *Vinayapiṭaka*.

Based on the limitations of using only the Pāli *Vinayapiṭaka* to inform a study of monasticism and medicine, I contend that a continued scholarly reliance on the Pāli canon perpetuates a skewed image of the relationship between medicine and Buddhism in early India. In particular, I argue that the inclusion of medicine in early monastic life, as evidenced by the MSV, does not demonstrate a monastic concern for the upholding of Buddhist philosophy. Rather, *vinaya* sources such as the MSV include a number of regulations involving medicine that serve as a testament to an early Indian Buddhist concern for the provision of care by monks for monks, as well as by monks for wealthy laity. Ultimately, I argue that the relationship between medicine and monasticism in early Indian Buddhist history is inherently tied to monastic concerns for the economic security of the Buddhist corporation.

Medicine, Monks, and the Middle Way

The understanding that a follower of Buddhism must maintain a lifestyle that is neither lavish nor austere, but one of moderation, is inherently connected with Buddhist soteriology – working towards the alleviation of suffering and attainment of nirvana. The principle of the Middle Way derives from the basic Buddhist tenets of the Four Noble Truths, and, in particular, the Eight-Fold Path. In *Asceticism and Healing*, Zysk draws a

connection between the doctrine of the Middle Way and the utility of medicine for early monastic groups, arguing that the inclusion of medicine in early Indian Buddhist life was motivated by the doctrine of the Middle Way. He writes,

> Providing the means to restore and maintain a healthy physical balance, medicine therefore was ideally suited to this philosophy of the Middle Way … . The record of the Buddhists' acquisition and development of a teaching pertaining to medicine and healing and fitting into the Buddha's doctrine of the Middle Way can be traced to the Pāli canon.[19]

Although the integration of medical content into the Pāli *vinaya* bears further attention, the connection between the ethical concerns of the doctrine of the Middle Way and the legal codification of rules pertaining to medicine is tenuous. While the doctrine of the Middle Way provides one possible (albeit unlikely) reason for the inclusion of medicine in monastic legal literature, it bears further consideration that there may have been other reasons for monks to foster a relationship with the world in which they lived. As Clarke explains:

> The vision of the monastic life that emerges from a study of the extant monastic codes is not what Buddhist monks told others, particularly the laity. Rather, it seems to reflect what they told themselves, what monks told other monks about their own institutions and traditions, and how they understood Buddhist monastic religiosity … . The authors/redactors of the extant *vinaya*s are primarily

[19] Zysk 1991: 39.

> concerned not with ethics or morality but with the preservation of the religious institution and its public image.[20]

With this understanding, it does not follow that the authors/redactors of the Pāli *Vinayapiṭaka* included rules about medicine to enforce the Buddhist teaching of the Middle Way. Rather, one must consider the utility of medicine for the wellbeing of monastics; that for the sangha to function, monks needed to maintain a basic standard of health and wellbeing. Thus, the medical rules in the Pāli *Vinayapiṭaka* are not an expression of early Buddhist concern for the relationship between medicine and the philosophy of the Middle Way, but for the relationship between healthy monks and the laity with whom they interacted on a regular basis.

To demonstrate the relationship between medicine and the Middle Way in early Indian Buddhism, Zysk draws on two instances of the use of cow-urine medicine in the Pāli *vinaya*. In the first, Zysk argues that the inclusion of cow-urine is representative of an early ascetic extreme; in the second, he presents cow-urine medicine as representative of a later development in Buddhist medical thought. With regards to the former, Zysk explains:

> The tradition preserved in the *Vinaya* specifies that a new monk of the *saṅgha* was provided with four resources (*nissaya*): meals of morsels of food (acquired by begging), robes of rags from dustheaps, lodging at the food of trees, and putrid urine (of cattle) as medicine (*pūtimuttabhesajja*) … . These four bare necessities of life probably derive from an early stage of *saṅgha* development, when monks

[20] Clarke 2014: 11.

> and nuns actively practiced the ideal of a wandering, nonpermanent life-style, because they were never made compulsory by the Buddha, and likely reflect ascetic practices of certain mendicants deemed to be too extreme for the Buddha's middle course.[21]

Zysk's reading of this passage concludes that because this particular story referencing cow-urine as medicine is not written in the words of the Buddha, the inclusion of cow-urine medicine by the authors/redactors in the Pāli *Vinayapiṭaka* harkens back to a wandering ascetic ideal. Consequently, using the doctrine of the Middle Way as one possible reason for why the Buddha did not make cow-urine compulsory, Zysk does not present other possible motivations for why cow-urine may have been included amongst the list of the four necessities in the Pāli *vinaya*.

Taken from the first section of the *Mahāvagga*, following the ordination of a gluttonous brahmin, the four necessities are introduced as rules for ordination, as Horner translates:

> I allow you, monks, when you are ordaining, to explain four resources. …[The fourth being] that going forth is on account of ammonia as a medicine; in this respect effort is to be made by you for life.[22]

In the Pāli *vinaya*, this passage consists of questions intended to test the dedication of novice members, rather than simply a description of necessities that were afforded to new renunciants. That is, in order to be ordained, a prospective monk must be willing to rely solely on cow-urine as medicine, in addition to the three other austere conditions, thereby

[21] Zysk 1991: 39–40.
[22] Horner 1938–1966, 4: 75.

proving his commitment to a monastic life free from luxury. However, one cannot assume that agreeing to the consumption of cow-urine as medicine suggests that monks used only cow-urine medicine when ill.

For example, the MSV provides further details as to the parameters surrounding this rule; after the prospective renunciant has made his agreement to comply with the four austere conditions, he is then given permission to consume a number of medicaments.[23] As Schopen translates:

> When the supernumerary is acquired – clarified butter or sesamum oil or honey or treacle or seasonable medicine is to be taken for a week or medicine to be used for life or medicine made from roots or stalks or leaves or flowers or fruits or any other suitable medicine that is acquired from the community or an individual.[24]

The addition of other medicaments in the MSV implies that once a prospective renunciant has agreed to rely on the four resources, he was not expected to use only cow-urine as medicine. The inclusion of sumptuous foodstuffs such as honey and fruits suggests that the intention behind this passage is not motivated by the use of cow-urine medicine itself, but instead to gauge the dedication of prospective members.

Zysk juxtaposes the "ascetic extreme" of relying on cow-urine as a medical necessity with the codification of cow-urine medicine as a permissible treatment for snakebites.[25] He argues that because the use of cow-urine in this instance is applied to a specific ailment, likely rooted in Āyurvedic principles, and codified in monastic legal

[23] Schopen [1983] 2004a: 243–244.
[24] Ibid.
[25] Zysk 1991: 40.

literature written in the words of the Buddha, it represents a shift towards a monastic medical tradition that moderated the use of cow-urine as medical treatment amongst a variety of other medicines – according with principles of the Middle Way. He writes:

> As a more settled existence in monastic establishments displaced the wandering life, four "possessions" (*parikkhāra*), modeled on the four "resources," superseded the latter as more appropriate for a stable and permanent lifestyle … . Medicines included all those things necessary for the care of the sick, and were to be used only to ward off and maintain health, never to give pleasure … . With the evolution of the *saṅgha* and the development of the *Vinaya* rules, the medicines grew into an entire pharmacopoeia.[26]

Here we see the conflation of *vinaya* laws in the Pāli canon with the historical actions of monks and nuns in early Buddhist history. Problematically, the Pāli *Vinayapiṭaka* is taken as representative of not only early Buddhist medical thought, but also medical practice, leaving little room for the consideration of other reasons for which cow-urine medicine may have been codified.

Zysk argues that a distinctly Buddhist medical tradition in early Indian history is attributable to the fact that "exclusive to Buddhist monastic medicine is the list of five basic medicinal foods."[27] The "five basic medicinal foods" to which Zysk refers are listed in the Pāli *Vinayapiṭaka* as five "basic medicines" for monastics: butter, ghee, honey, oil, and molasses.[28] While the inclusion of medical practices in the Pāli

[26] Ibid.
[27] Ibid. 83.
[28] Horner 1938–1966, 1: 133.

Vinayapiṭaka demonstrates that monks certainly possessed knowledge of medicaments in early India, there is little that is distinctly Buddhist about the medicines listed in the Pāli *vinaya*. References to medicine in the *Bhesajjakhandaka*, the section on medicines in the Pāli *vinaya*, includes a variety of *materia medica*, such as decoctions from tree bark, fruits, leaves, resins, roots, salts, and tallows listed as permissible for the treatment of minor afflictions such as eye disease, headaches and scabs.[29] Even raw animal flesh and blood is permitted in certain circumstances.[30]

Developing Buddhist ideologies and practices were undeniably affected by the society in which they existed, and it is of no surprise that there is overlap between the medical content of *vinaya* literature and some of the earliest medical treatises of what is recognized today as Āyurvedic medicine. According to Dominik Wujastyk, each of these five basic medicines can also be found in the compendia of Suśruta and Caraka.[31] For example, Caraka's list of medicines that are to be contained within a hospital includes ghee, butter, oil, honey, and molasses.[32] Thus, while it appears to be true that there is no specific list of these five medicines as forming a class of "basic medicines" outside the Buddhist tradition, or at least none has been identified, the knowledge of these items as medicines was already in existence before the redaction of the Pāli *Vinayapiṭaka*.

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[29] For a translation of the *Bhesajjakhanda*, see Horner 1938–1966, 4: 269–329; decoctions of tree bark, p. 272; fruits as medicine, pp. 272–273; leaves as medicine, p. 272; resins as medicine, p. 273; tallows as medicine, pp. 270–271; roots as medicine, pp. 271–272; salts as medicine, p. 273; treatment of eye disease, p. 275; treatment of headaches, pp. 277–278; treatment of scabs, pp. 273–274.
[30] Horner 1938–1966, 4: 274.
[31] Wujastyk 1998. Examples include: the use of ghee and butter for the treatment of poison (p. 139); oil for the removal of a blockage in the windpipe (p. 109); honey for the treatment of phlegm (p. 228–9); and molasses for the treatment of winter idyll (p. 220).
[32] Wujastyk 1998: 37.

Moreover, the description of these items as "sumptuous foods"[33] in the Pāli *Vinayapiṭaka* indicates that they were acknowledged, first and foremost, as foodstuffs. It is likely that since the monastic community relied on the laity for the procurement of medicines and foodstuffs, the basic medicines of the monastic institution would therefore need to be relatively easy to obtain, resulting in a list of five accessible medicines.

In the Pāli *Vinayapiṭaka*, permitted medicines beyond the basic five are described in great detail, yet the authors/redactors of the Pāli *vinaya* do not dwell on the medical properties of these substances. Aside from restricting monks and nuns from keeping the five basic medicines for more than seven consecutive days, the Pāli *vinaya* provides very few instructions as to how these medicines are to be used.[34] Regulations related to the use of medicines appear to show a concern with upholding a good public image. For example, the Pāli *vinaya* specifies, in the words of the Buddha, that the laity perceive these five medicines to be sumptuous foods, and as such, the consumption of the five medicines by monks who are not sick is prohibited.[35]

Medicine, Monks, and Medical Men

With the establishment and spread of monastic communities, and a rise in monastic reliance on donations for the procurement of food and material goods, the need for the sangha to develop and maintain a positive relationship with the laity also increased. The

[33] Horner 1938–1966, 2: 341.
[34] It is of note that the use of oil as medicine is briefly touched on in Horner (1938–1966, 4). The Pāli *vinaya* does contain instances of oil being permitted for the treatment of headaches (p. 277) and afflictions of wind (p. 278).
[35] Horner 1938–1966, 4: 269.

second part of Zysk's argument considers the role of medicine in shaping the lay-monastic relationship. He contends that while monastics were initially restricted to providing care only to one another, by the third century BCE, monk-healers provided medical care to the greater lay population.[36] Consequently, Zysk argues that the monastery became a centre for healing, appealing to traveling laity. In return, these "patients" made donations to the sangha, leading Buddhism to flourish throughout the subcontinent.[37] The next two chapters of this thesis will demonstrate the complexities of the relationship between Buddhism and medicine in early Indian history by arguing that while monks may have provided medical care to wealthy laity, MSV and epigraphic evidence suggests that, in fact, monks did not work as physicians for the population at large, as lay physicians appear to have supported the monastic community both economically and medically.

The *Bhesajjakhandaka* contains the most references to permitted medicines and their application in the Pāli *vinaya*, with only a small number of references to physical ailments and medical treatments appearing outside of this section. While the Pāli *vinaya* indicates an acute social awareness of the risk (and likely high incidence) of illness amongst monastic groups, all we can safely conclude based on this section of the Pāli *Vinayapiṭaka* is that the authors/redactors were promoting a need for monastics to understand basic methods of medical care – generally the use of the five medicines (butter, ghee, honey, oil, and molasses) as well as a variety of foodstuffs and ointments with medicinal properties.

[36] Zysk 1991: 44.
[37] Ibid.

Zysk claims that details about the monk-healer vocation were included by the authors/redactors of the Pāli *Vinayapiṭaka* so as to identify "the qualities (*aṅga*) of difficult and easy patients and of competent and incompetent nurses (*gilānupaṭṭhāka*)."[38] In the Pāli *Vinayapiṭaka*, the monk providing care for another monk is expected to acquire appropriate medicines, and clean the sick monk from vomit and mucus; the sick monk is responsible for explaining his symptoms to his caretaker, and accepting the given medicines. In reference to this set of passages, Zysk writes:

> Codification of the qualities of medical personnel and of patients finds an early formulation in the institutions of the early Buddhist *saṅgha*, reflecting the Buddhists' increased involvement with medicine and their preservation and development of medical doctrines that find parallels in the Āyurvedic tradition, albeit with obvious brāhamaṇic accretions.[39]

Based solely on the Pāli *vinaya*, the implication that a sick monk and his caregiver functioned as "patient" and "medical personnel" suggests that monks cared for one another through medical relations. Yet the most specific type of care noted in this *vinaya* passage that one monk is instructed to provide to another is to "delight the sick with *dhamma*-talk."[40] In his discussion of the role of the monk as a caregiver, based on this same Pāli passage, Demiéville (trans. Tatz) describes the role of the caregiving monk as

[38] Ibid. 41.
[39] Ibid. 43.
[40] Horner 1938–1966, 4: 433.

being for the purpose of giving "spiritual relief" to the sick monk – noting that a physician (not a monk-healer) is summoned only as a last resort.[41]

Nevertheless, Zysk maintains that because of the vast storehouse of monastic medical knowledge derived from its roots in the tradition of wandering ascetics, the Buddhist medical tradition became a central, institutionalized component of monastic life. He writes:

> The medical doctrines codified in the monastic rules … gave rise to monk-healers and to the establishment of monastic hospices and infirmaries, and proved to be beneficial assets in the diffusion of Buddhism throughout the subcontinent during and after the time of Aśoka.[42]

Central to this part of his argument, Zysk writes that the monastic institution "extended medical care to the population at large,"[43] promoting the rise and spread of Buddhism within, and beyond India.

To support his claim, Zysk draws on a set of inscriptions commanding the provision of medical care on the Second Rock Edict of Aśoka as evidence.[44] In reference to Zysk's use of epigraphical evidence, Jonathan Silk convincingly argues that while the Second Rock Edict demonstrates that Aśoka was likely heavily invested in medical provisions, Aśoka's intention to provide health care cannot be conflated with the intentions of the monastic institution. Silk writes:

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[41] Demiéville (trans. Tatz) 1985: 31.
[42] Zysk 1991: 118.
[43] Ibid. 44.
[44] For more information on the misinterpretation of the Second Rock Edict of Aśoka in contemporary scholarship, and Silk's contestation of Zysk's claims, see Chapter 3.

> That Aśoka may have been, in some sense, a Buddhist (though certainly never a monk) cannot be taken to mean that his royal and governmental efforts to promote social welfare may be credited to the monastic community.[45]

In accordance with Silk's argument, along with Clarke's characterization of *vinaya* literature discussed above,[46] it would appear that the roles and duties associated with medicine were not for the benefit of the population at large, but primarily for the provision of basic levels of care by monks for monks.[47]

Looking at the Pāli *vinaya* as a literary genre, the "sick monk" is used as a literary device applied by the authors/redactors in order to introduce or refine *vinaya* regulations that are more concerned with how to act properly when ill, rather than the diagnosis or treatment of such illnesses. Indeed, instances of sick monastics in the Pāli *Vinayapiṭaka* are unsurprisingly common; yet the majority of such instances have very little to do with the specific diagnosis and treatment of illness. While scant details of illnesses or medicines are given outside the discussion of *materia medica* in the *Bhesajjakhandaka,* instances of sick monks throughout the Pāli *Vinayapiṭaka* provide further evidence for an early monastic concern with the sangha's public image, not the provision of care for the laity.

A handful of stories in the *Bhesajjakhandaka* appear to caution monastics against acting as physicians for those around them. For example, stories that tell of monks attempting to provide care to their sick brethren result in the death of the sick monk in

[45] Silk 2008: 8.
[46] See pp. 15–16.
[47] Silk 2008: 7.

each narrative.[48] Additionally, two consecutive stories of laywomen approaching monks for medical attention also conclude with each woman's death.[49] If early Buddhist monks were indeed doctors, the authors/redactors of the Pāli *vinaya* certainly do not present them in a positive light.[50] The Pāli *vinaya* also includes a handful of instances wherein a sick monk is allowed to go home for treatment.[51] One must question why an ill monk was permitted to journey to see his family rather than remain at the monastery for treatment, as Zysk's argument would seem to suggest would have been the norm.

Other narratives concerning sick monks in the Pāli *Vinayapiṭaka* generally pertain to the establishment of allowances for the modification of monastic behaviour in the event of illness, but do not denote any particular attention or details to the illness, proper. Such instances are typically presented as refinements to previously established rules, as a provision in the event of illness. To give but a few examples: only monks who are not ill are permitted to sweep the observance hall;[52] an ill monk is allowed to travel in a vehicle, specifically a handcart yoked with a bull;[53] and a sick monk is permitted to enter a village with his sandals on.[54] While these regulations do pertain to illness, they appear more concerned with how a monk can remain in good standing when he encounters illness. Although these rules convey greater insight towards the daily life of the Buddhist monk,

[48] Horner 1938–1966, 1: 143–144.
[49] Ibid. 144–145.
[50] For a list of medical instances in *The Book of the Discipline*, by I.B. Horner, see the Appendix.
[51] Horner 1938–1966, 2: 13–15, 80.
[52] Horner 1938–1966, 4: 155.
[53] Ibid. 255–256.
[54] Ibid. 260.

they do not stand as conclusive evidence for "medicine and healing [as] integral parts of Buddhist monasticism from its inception," as Zysk contends.[55]

The Pāli *vinaya* also contains specific references to non-Buddhist doctors, but describes them very differently than monks who engage with medicine and/or medical practice. For example, the *Bhesajjakhandaka* contains several stories of Jīvaka Kumārabhṛta, a legendary physician associated with the Buddhist tradition (although not a monk), and an alleged attendant of not only the king, but also the Buddha himself in times of illness. Jīvaka's surgical treatment of ailments such as head disease[56] and twisted bowels[57] suggests that surgery was not unknown to the authors/redactors of the Pāli *vinaya*, yet there are no such accounts of monks performing surgeries in the Pāli *vinaya*.[58] Demiéville (trans. Tatz) states that while knowledge of medicaments was likely fairly widespread amongst monastics, the medical vocation is, by and large, condemned in extant *vinaya* sources.[59] He further summarizes two instances of sick monks consulting secular physicians in both the *Mahāsāṃghika-vinaya* and the *Mūlasarvāstivāda-vinaya*.[60] Indeed, if the Buddhist monastic institution was rife with medically-knowledgeable monks, then why did the merchants and kings of these stories

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[55] Zysk 2001: 44.
[56] Horner 1938–1966: 4, 385.
[57] Ibid. 389–390.
[58] Naqvi 2011: 140–173 outlines a series of discoveries of surgical implements from the Gandhara region dating back to c. 3rd century BCE. These discoveries include (but are not limited to) forceps and scalpels from the 1st century BCE, suturing needles from the 2nd century BCE, and surgical spatulae from the 2nd century BCE.
[59] Demiéville (trans. Tatz) 1985: 36. For more information on Buddhist interdictions against the practice of medicine by nuns, see Langenberg's (2014) article "Female Monastic Healing and Midwifery: A View From the *Vinaya* Tradition."
[60] Demiéville (trans. Tatz) 1985: 36.

seek out lay physicians rather than the monk-healers who, as Zysk contends, were spreading medical care across the subcontinent?

To characterize further the developing relationship between monastics and laity, Zysk writes that the presence and positive portrayal of non-monastic physicians in the Pāli *Vinayapiṭaka* is demonstrative of a close association between Buddhist monastics, Buddhist laity, and traditional practitioners, "[establishing] a close link between Buddhist monasticism and ancient Indian medicine."[61] Indeed, the strong presence of a developed Indian medical tradition outside of Buddhism does become clear in the Pāli *vinaya*. Two examples of the non-Buddhist physician Jīvaka stand out in particular: Jīvaka is called to tend to the head disease of a merchant's wife; in the other, he tends to the head disease of a merchant. Both stories comment that Jīvaka's help was sought only after "many very great, world-famed doctors … had not been able to cure" the ill person.[62] Both of these stories acknowledge the existence of high-standing physicians in early Indian society. Jīvaka's brief biography also points to his medical education as having been directed by a doctor, not a monk.[63] One cannot help but note that a distinction between monks and doctors is clear in the *Book of the Discipline*.

With regards to the medical regulations codified in the Pāli *vinaya*, there are a number of specific ailments for which the authors/redactors of the Pāli *Vinayapiṭaka* permit specific medicines. Treatments include, but are not limited to, the five basic

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[61] Zysk 1991: 93.
[62] Horner 1938–1966, 4: 383, 386.
[63] According to Jinananda (1953: 73), while the MSV version of this story refers specifically to the famed Ātreya as the doctor-teacher of Jīvaka, the Pāli *Vinayapiṭaka* account of this story does not name Jīvaka's teacher.

medicines: ghee, fresh butter, oil, honey, and molasses. Common ailments include minor afflictions such as constipation, headaches, scabs, and wind, as well as more serious afflictions such as poison, rheumatism, and snakebites. As Zysk rightly points out, these ailments and the treatments thereof were likely quite common in India around the turn of the Common Era.[64]

The *Bhesajjakhandaka*,[65] the chapter on medicines in the Pāli *Vinayapiṭaka*, contains several stories that are structured in a stenciled way: a monk is suffering from some sort of physical ailment, falls ill, and, in response, the Buddha expands the list of permissible medicaments beyond that of the five basic medicines.[66] In reference to these stories, Zysk writes,

> These case histories provide a clear picture of medical practice current in the Buddhist monastery in the centuries preceding the Common Era. The ailments treated are generally minor and represent typical afflictions suffered by Buddhist cenobites in the early *saṅgha*.[67]

Zysk goes on to list eighteen case histories[68] that, he writes, functioned as a "handbook and guide for the treatment of common afflictions."[69] Herein lies one of the most

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[64] Wujastyk (1998) provides selections of *Ayurvedic* texts that would likely have been well integrated throughout India by the turn of the Common Era. In particular, many passages heavily emphasize afflictions related to wind disease and ailments of the bowels.
[65] Horner 1938–1966, 4: 269–350.
[66] See n. 68.
[67] Zysk 1991: 84.
[68] These case histories are listed in Zysk 1991: 85–116. In sum, the eighteen ailments discussed are: large sores (pp. 85–86); nonhuman disease (pp. 87–88); eye disease (pp. 88–91); head disease (pp. 91–92); affliction of wind (pp. 92–23); wind in the limbs (pp. 93–95); wind in the joints (pp. 95–96); split-open feet (pp. 96–98); swellings (pp. 98–

problematic aspects of Zysk's framework: the conflation of text and practice, which leads Zysk to confuse Buddhist medical knowledge with widespread medical practice throughout *Asceticism and Healing*.

Medicine, Monks, and Money

The economic incentives for medical knowledge and medical practice in early Buddhist monasticism are found in both the Pāli *vinaya* and other extant *vinaya* sources, such as the MSV. In this section, I contend that Zysk's thesis upholds a romanticized view of the inception of Buddhism in India, and ignores the possibility of a social reality in which monastics may have been more concerned with wealth than medical practice. Zysk posits that Jīvaka's association with Buddhist monastics became popular amongst the laity, and "creat[ed] problems for the *saṅgha.*"[70] Although Zysk does not point to a particular passage in the Pāli canon, a similar sentiment is expressed in at least one instance in the Pāli *Vinayapiṭaka*: a sick man joins the sangha in order to gain access to Jīvaka's treatments, with the intention of leaving the sangha after he is healed. Upon his departure from the sangha, the Buddha decrees that the monks are not to ordain one who is afflicted

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101); snakebite (pp. 101–103); effects of harmful drink (pp. 103–105); defective digestion (pp. 105–106); morbid pallor or jaundice (pp. 106–107); corruption of the skin (pp. 107–108); body filled (with the "peccant" humors) (pp. 108–110); wind in the abdomen (pp. 110–113); burning in the body (pp. 113–114); and rectal fistulae (pp. 114–116).

[69] Zysk 1991: 71.

[70] Zysk 1991: 43.

with disease.[71] The authors/redactors of the Pāli *vinaya* seem to recognize that, particularly for those in need of care, the sangha is a desirable place.

Using the MSV, Schopen describes the monastery as a facility for care that came to be central to the procurement of revenue and likely material goods of high value and even property. Schopen tells us that the provision of medical care to rich laity was far from condemned. One instance that he points to in particular is a passage from the *Cīvaravastu* in the MSV, wherein an elderly householder – rich and childless – requests to join the sangha. Before he can be fully ordained, the householder becomes terminally ill. This incident leads to the creation of a new category of lay status, that of the "shaven-headed householder," whom the monks are instructed to care for as if he were an ordained monk.[72] After the shaven-headed householder passes away, he leaves his estate to the sangha. The authors/redactors of the MSV clearly indicate that old and even sick householders, who are childless and wealthy, are allowed to be taken into the sangha under the formally unwritten, yet apparently socially accepted, expectation that upon death, the sangha becomes the legal heir to their estate.[73]

Even the provision of medical care by monks to their sick brethren may have been motivated by the promise of economic gains. As described in the Pāli *vinaya*, the symbiotic relationship between the sick monk who is easy to tend and a monk competent to provide care ultimately benefits the public image of the sangha. In support of his argument for the early monastic codification of a Buddhist medical tradition, Zysk draws

[71] Horner 1938–1966, 4: 90–91.
[72] Schopen 2000: 98–99.
[73] Ibid. 100.

on one of the most famous and oft-cited *vinaya* passages: a story wherein the Buddha happens upon a monk who is suffering from dysentery and left uncared for by his fellow monastics. The Buddha instructs:

> Monks, you have not a mother, you have not a father who might tend you. If you, monks, do not tend to one another, then who is there who will tend you? Whoever, monks, would tend me, he should tend the sick.[74]

As monastic legal literature that was written by monks, for monks, it makes sense that a precedent is set for monks to care for one another in times of need. The passage continues to explain the qualities of a monk who is easy to tend, a monk who is difficult to tend, a monk who is fit to provide care, and a monk who is unfit to provide care.[75]

Following this passage, the Buddha further decrees that should the ill monk pass away, the caregiver is permitted to keep the bowl and robes of the ill monk. In regards to this proclamation, Zysk comments:

> The act of nursing a monk who fell ill was considered to be such a great service that when the monk passed away, his begging bowl and robes were given to the one who nursed him … an institution of monk-healers, utilizing medical doctrines codified under the monastic rules, thus evolved … for the purpose of providing medical care to the sick in the *saṅgha*.[76]

Here Zysk suggests that the inclusion of these rules about inheriting the belongings of a sick monk is for the purpose of acknowledging the efforts of the caregiver. However,

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[74] Horner 1938–1966, 4: 432.
[75] Ibid. 433.
[76] Zysk 1991: 42.

while this is one possible explanation, it may not be the only motivation behind the codifications of such a provision.

For example, Schopen also comments on this passage, albeit on the version found in the MSV, shedding light on a different intention conveyed by the authors/redactors. He suggests:

> These rules make, of course, a very attractive arrangement, which if implemented would have provided for Mūlasarvastivādin monks unparalleled security for long-term care … these monks would have been very well looked after in their final days, and this, in turn, may have been a powerful motivating factor in an individual's decision to enter the order.[77]

While a monk's tending to a fellow monastic may suggest Buddhist inclinations towards medical practice, there were also strong economic incentives beyond that of caring for another monk. The intention behind this passage may reflect a number of reasons that motivated the authors/redactors of early *vinaya* codes. As suggested by Schopen,[78] such a regulation would likely have attracted new members, promoting the image of the sangha in a favorable light.

This chapter demonstrated how Zysk's reliance on the Pāli canon, and subsequent conflation of *vinaya* law codes with monastic medical practice, transmits an incomplete picture of Buddhism and medicine to contemporary audiences. In the following chapters, I will delve further into the monastic vocation, using the MSV, Brahmanical law, and the

[77] Schopen 2000: 96.
[78] Ibid. 99.

Indian epigraphic record to illuminate further the relationship between Buddhism, monasticism, and medicine, in early Indian history.

Chapter 2

The Anomaly of Jīvaka: The Influence of Brahmanical Jurisprudence on Mūlasarvāstivādin Monks

The institutionalization of Indian Buddhist monasticism was undeniably shaped by the Brahmanical jurisprudence that dominated early Indian society; *Dharmasūtra* and *Dharmaśāstra* laws regulated the political structure and social conduct of many patrons of the sangha. Tensions arose between orthodox politics and emergent Buddhist thought, as the authors/redactors of Buddhist legal literature did not always agree with the content of the *Dharmasūtra*s and *Dharmaśāstra*s. Indeed, Brahminical laws justify these tensions, particularly as they caution citizens against giving food to physicians. Since the Buddhist institution required a strong rapport with the laity, the relationship between monastics and medicine became complicated further as the Buddhist institution had to reconcile its own legal codes with the political concerns of the society in which it existed. One such example of this process can be seen in the MSV, regarding the ways in which monks are permitted to interact with medicine and the provision of medical care; the medical vocation is denounced by the authors/redactors of *Dharmasūtra*s, treating physicians as belonging to the same social class as criminals, prostitutes, and hunters, based on a shared association with impurity.

Based on *Dharmasūtra* and *Dharmaśāstra* law codes,[79] it is clear that the Brahmanical tradition situated physicians within the lowest caste of society. In *Buddhist*

[79] In my discussion of *Dharmasūtra* literature, I rely primarily on Patrick Olivelle's (1999) translations of four extant Dharmasūtra collections in *Dharmasūtra: The Law Codes of Āpastamba, Gautama, Baudhāyana, and Vasiṣṭha*.

Monks and Business Matters, Schopen draws significant connections between the content of the *Dharmaśāstra*s and the MSV. He writes:

> Buddhist *vinaya* – especially, it seems, the *Mūlasarvāstivāda-vinaya* – can no longer be studied in isolation from Dharmaśāstra … it is becoming even clearer that the *Mūlasarvāstivāda-vinaya* may have particularly close ties to brahmanical concerns, and this, in turn, may again suggest that it was redacted by a community deeply embedded in the larger Indian, brahmanical world.[80]

Schopen characterizes the ways in which *Dharmasūtra* laws required Mūlasarvāstivādin monks to be acutely "concerned with representing their Community to their fellow monks as sensitive to and accommodating towards the norms and values of what they took to be their surrounding community."[81] The study of medicine in ancient India, and particularly the rules surrounding medicine and medical treatment in the MSV, brings to light tensions between the condemnation of medical practice in the *Dharmasūtra* and *Dharmaśāstra* law codes, and the utility of medicine for the economic development of the early Buddhist sangha.

Rather than condemn medicine and medical practice, similar to other *vinaya* traditions, the authors/redactors of the MSV included important information about permitted medicaments, as well as ways in which medical care could be provided to other monastics and even, in certain cases, the laity. In this chapter, I argue that the MSV demonstrates an early Indian Buddhist effort to reconcile the social denigration of

[80] Schopen 1994: 553.
[81] Schopen 2001: 138.

physicians, as seen in *Dharmasūtra* and *Dharmaśāstra* texts, with the economic utility of medicine for the Buddhist sangha. That is, in light of the rejection of physicians in Brahmanical jurisprudence, early Indian Buddhists were more concerned with distinguishing themselves from the practices of worldly physicians, rather than rejecting medical practice proper.

This chapter focuses on the ways in which medical practice and the role of physicians were rejected by the authors/redactors of Brahmanical law, resulting in the marginalization of physicians from Indian society. I begin with an exploration into references to medicine and medical practice in *Dharmaśāstra* and *Dharmasūtra* laws, in order to assess the development of the Brahmanical worldview of physicians. Central to my discussion is the relationship between food and medical practice. Indeed, the majority of medicines in ancient India were, by and large, foodstuffs. Based on available texts, the condemnation of physicians appears to be well ingrained in Indian society by the time of the Buddha, and likely played an integral role in shaping the foundation of the relationship between early Indian Buddhist monasticism and medicine.

In particular, I contend that preexisting ideas condemning medical practice in Brahmanical law codes posed a threat to the wellbeing of the lay-monastic relationship. Indeed, it would not do for monks to be confused with doctors by the wider population. Drawing from the Mūlasarvāstivādin account of the biography of the legendary Indian physician Jīvaka, I argue in the latter part of this chapter that this story serves as an example of how the authors/redactors of the MSV created space for a permitted relationship between monks and medicine. Through a close reading of the Jīvaka

biography from the MSV, it becomes apparent that early Indian monasticism was able to work around *Dharmaśāstra* and *Dharmasūtra* laws in order to create legal space for the foundation of a positive relationship between monks and medical practice, primarily for economic gains, as the previously discussed story of the shaven-headed householder suggests.[82] While the story of the shaven-headed householder cannot be generalized to imply that monks provided medical care for the entire lay community, MSV evidence points to further economic and social complexities that define the relationship between monks and medicine.

Keeping the Doctor Away in *Dharmasūtra* and *Dharmaśāstra* Laws

Across religious texts and *Dharmasūtra*/*Dharmaśāstra* materials, the physician maintains a subordinate status in the hierarchy of the early Indian caste system. While the dates and authorship of the four extant *Dharmasūtra* collections are sketchy,[83] they can be broadly placed between 600 and 100 BCE.[84] The reach of these laws was extensive, as *Dharmasūtra* materials informed the social regulation of diverse aspects of social and religious life in India.[85] Patrick Olivelle explains:

> *Dharma* includes all aspects of proper individual and social behaviour as demanded by one's role in society and in keeping with one's social identity

[82] For the story of the shaven-headed householder, see pp. 31–32.
[83] Namely, the law codes of Āpastamba, Baudhāyana, Gautama, and Vaśiṣṭha.
[84] Olivelle (1999) cautions that although Kāṇe's (1962, 2: xi–xii) suggestion that *Dharmasūtra* materials were authored and redacted between 600 BCE and 300 BCE is typically accepted, this dating is based on a comparative chronology with other ancient Indian texts, rather than internal evidence from the *Dharmasūtra* texts themselves.
[85] Olivelle 1999: xxi.

> according to age, gender, caste, marital status, and order of life … . The subject matter of the Dharmasūtras, therefore, includes education of the young and their rites of passage; ritual procedures and religious ceremonies; marriage and marital rights and obligations; dietary restrictions and food transactions; the right professions for, and the proper interactions between, different social groups … .[86]

Indeed, ritual interactions between early Indian monastics and the laity were likely heavily informed, at least in early Buddhist history, by the regulations enforced by the dominant Brahmanical class. As such, the role of medicine in ancient Indian life was not exempt from the concerns of the authors/redactors of *Dharmasūtra* and *Dharmaśāstra* laws.

The caste system that regulated early Indian life informed the types of political regulations instated by the Brahminical class, informed by orthodox religious understandings. In *Science and Society in Ancient India*, Debiprasad Chattopadhyaya discusses how the hierarchical structure of early Indian society, with religious leaders at the top, was threatened by the scientific knowledge of physicians. He posits:

> The ancient Indian doctors are thus dragged into politics, without ever intending to be politicians themselves. They aspire to be too severely scientific to remain unnoticed by the establishment. To question – even by implication – mysticism, ritualism and religion necessitates also the rejection of the very way of life which

[86] Ibid.

> all these intend to justify. In short, it amounts to the tendency of questioning the very norm on which the hierarchical society wants to thrive.[87]

Thus the religious and political precedent set by Brahmanical leaders set the stage for the rejection of medicine from religious associations, even before the institutionalization of Buddhism in India. Chattopadhyaya mentions in particular that the scientific goal of rationality and logic was particularly threatening to the conceptions of *karma* that upheld the caste system of the Brahmanic tradition.[88]

As Indian medicine continued to develop throughout the Saṃhitā period into the Brāhmaṇa period, ca.1100 BCE, negative orthodox attitudes towards physicians continue to develop.[89] For example, the *Yajurveda* (ca.1000–800 BCE) denounces the participation of physicians in sacrificial rites, based on the impurities associated with medical practice, and the resulting unsuitability for physicians to play a role in this religious rite. As Keith translates:

> The gods said of [the Aśvins], "Impure are they, wandering among men and physicians." Therefore a Brahman should not practise medicine, for the physician is impure, unfit for the sacrifice.[90]

This reference to the impurity of physicians marks a notable shift from the highly sanctified medical abilities of the Aśvins in the *Ṛgveda*, which predates both Indian

[87] Chattopadhyaya 1977: 5.
[88] Ibid. 10.
[89] Ibid. 273.
[90] *Yajurveda* vi.4.9. Taken from "The Explanation of the Soma Sacrifice" in A.B. Keith (trans.) 1914.

rational medicine and the solidification of the caste system, according to Chattopadhyaya.[91] As Arthur Macdonell explains:

> Next to Indra, Agni and Soma, the twin deities, called Aśvins, "Horsemen," are the most prominent gods in the *Rigveda*, being invoked in more than 50 entire hymns and in parts of several others.[92]

This shift in religious conceptions of physicians resulted in ideological requirements for the caste system that ultimately diminish the status of the physician in *Dharmasūtra* texts.

Extending from these views that denounce the inclusion of physicians in religious and social practices, medical practice proper also becomes regarded as a sin that causes an immediate loss of status. As we see in the *Dharmasūtra* of Baudhāyana:

> Next, the secondary sins causing loss of caste: sexual intercourse with a woman with whom sex is forbidden … practising medicine … and other similar professions, as well as violating virgins. The expiation for these is to live as an outcaste for two years. (Baudhāyana 2.2.12–14)[93]

The rejection of physicians and medical practice by the upper tiers of society is presented quite explicitly in this passage. As we see, one who makes a profession out of medical practice would necessarily endure the sentence of an outcaste for more than two years, further pushing him to the margins of society for longer periods of time. Interestingly, the

[91] Chattopadhyaya 1977: 6.
[92] Macdonell 1922: 41.
[93] Olivelle 1999: 168–9.

Dharmasūtra of Baudhāyana, however, seems to be the only *Dharmasūtra* text to reference explicitly the sinful nature of medical practice.

The *Dharmaśāstra* law codes of Manu, *Manusmṛti*, composed between 200 BCE and 200 CE, further condemns the place of the physician in the Indian social structure. In accordance with the need for ritual purity in Indian society, the *Manusmṛti* lists means other than medical intervention that allow for a healthy life. For example, as Bühler translates:

> (The pursuit of sacred) knowledge is the austerity of a Brāhmaṇa, protecting (the people) is the austerity of a Kṣatriya, (the pursuit of) his daily business is the austerity of a Vaiśya, and service the austerity of a Śūdra … . Medicines, good health, learning, and the various divine stations are attained by austerities alone; for austerity is the means of gaining them. (Manu XI, 236, 238)[94]

By attributing good health to the ability of one to accord with the responsibilities associated with one's caste, the need for physicians is further suppressed. The *Manusmṛti* frames itself as the ideal medicine – and following its laws the best way to ensure health. Thus, if poor health is the result of one's actions, correcting one's behaviour is the treatment prescribed, not the foodstuffs prescribed by physicians.

Following the condemnation of medical practice as a sin, *Dharmasūtra* references to physicians are also contained amongst rules pertaining to the exchange of foodstuffs between physicians and other members of society. As will be demonstrated in the following excerpts, references to physicians in *Dharmasūtra* texts are found together

[94] Bühler 1886: 478.

with other outcaste groups also associated with impurity. Consider the following examples in which, with regards to accepting food, the *Dharmasūtra*s of Āpastamba, Gautama, and Vasiṣṭha all include physicians in their lists of unfit givers of food:

> The following are unfit to be eaten: food into which hair or an insect has fallen; what has been touched by a menstruating woman … [food given by] a hermaphrodite, a law enforcement agent, a carpenter, a miser, a jailer, a physician (*vaidya*), a man who hunts … (Gautama 17.9–17)[95]

> The following are unfit to be eaten: food given by a physician (*vaidya*), a hunter, a harlot, a law enforcement agent, a thief, a heinous sinner, a eunuch, or an outcaste; also that given by a miser, a man consecrated for a sacrifice, a prisoner, a sicker person … [etc.] (Vaśiṣṭha 14.2–3)[96]

> He shall not eat the food given by a corporate body or announced through public invitation; the food of anyone who lives by practicing a craft or using weapons; the food of a pawnbroker, a physician (*vaidya*), or an usurer … (Āpastamba 18.16–22)[97]

Presumably, references to the exchange of foodstuffs likely also include food that may have been prescribed by physicians as medicine. Thus, interdictions against accepting food from physicians also extend to the acceptance of medicines by members of society. As such, we can trace the marginalization of the physician in Indian society back to the

[95] Olivelle 1981: 108–9.
[96] Ibid. 285.
[97] Ibid. 29.

condemnation of not only medical practice as a sin, but also Brahmanical laws that result in legal interdictions against the acceptance of food from physicians.

Just as we saw in the *Yajurveda* and *Dharmasūtra* materials, the *Manusmṛti* also expresses negative views towards the presence of physicians at sacrifice rituals, and declares food given by physicians to be unfit for higher caste members.[98] As Chattopadhyaya describes:

> What [Manu] adds to the declaration is only a great intensity of contempt for such food: "the food received from a doctor is as vile as pus" (*pūyaṃ cikitsakasya annam*).[99] There is thus no question, from his point of view, of a *snātaka* (or one who has finished the scriptural studies) to accept such food … . The physician is supposed to be so impure that even food offered to him turns into something vile.[100]

However, this text also adds a new perspective to the social rejection of physicians: just as food is not to be given to physicians, so too are physicians deemed unfit to receive food. Consider the following passages:

> Physicians, temple priests, meat sellers, and those who live by trade – these should be avoided at divine and ancestral offerings. (Manu III, 152)[101]

> What is given to a seller of Soma turns into excrement; what is given to a physician turns into pus and blood; what is given to a temple priest perishes; what is given to an usurer lacks stability; what is given to a trader has no effect either in

[98] Chattopadhyaya: 1977: 214–15.
[99] Manu iv, 220, as cited by Chattopadhyaya (1977) on p. 214.
[100] Chattopadhyaya 1977: 214–15.
[101] Olivelle 2005: 116.

> this world or the next; and what is given to a twice-born man born to a remarried woman is like an oblation offered in ashes. The wise declare that the food given to other evil men enumerated above, men alongside whom it is unfit to eat, turns into fat, blood, flesh, marrow, and bone.[102]

Indeed, as will be discussed below, the specific relationship between physicians and foodstuffs, as demonstrated in the above legal sources, has important implications for our understanding of the relationship between monks and medicine. Additionally, the continuity of the denigration of the physician throughout the millennium before the Common Era suggests that the religious and political elite continually marginalized physicians throughout this time period.

Nevertheless, the Indian medical tradition continued to develop during the first millennium before the Common Era, resulting in the production of a number of texts now considered the foundations of *Āyurveda*. For example, as Chattopadhyaya translates from the *Caraka-saṃhitā*:

> We follow the following principles because all these are well-established by our direct observations: we cure the sick by sickness-removing drugs, the emaciated person with emaciation-removing agents. We cure the thin and sick persons with nourishment, just as we prescribe restrictions of food for the flabby and fatty persons. We treat with 'cold' those who are afflicted with 'hot' and with 'hot' those who are afflicted with 'cold'… . A physician who knows how to differentiate between the curable and incurable diseases and who, with proper medical

[102] Ibid. 117.

> knowledge, begins the treatment of the patient in time, is absolutely certain of attaining success.[103]

Composed in its earliest form around the second century BCE, the *Caraka-saṃhitā* promotes the utility of medical science. Based on an appeal to empirical evidence, the authors/redactors of the *Caraka-saṃhitā* shift away from religious dogma, and present an understanding of disease through a type of logical reasoning that ultimately formed the basis of Indian scientific laws.[104]

Making Room with the Medicine King in the *Mūlasarvāstivāda-vinaya*

The denigration of physicians by Brahmanical groups established a gap in early Indian society for the provision of medical care, as well as the social location of physicians in heterodox religious groups. By engaging with medicine and medical practice, the Buddhist sangha was able to gain both social and economic capital, while remaining in good standing in orthodox Indian society. The MSV makes a clear reference to one such way the authors/redactors may have approached the tensions between Brahmanical laws and Buddhist associations with the medical world. As Schopen paraphrases,

> … a young brahmin was staying in a hostel for young brahmins (*māṇavakaśālā*), but fell ill with vomiting and diarrhea. Rather than attend to him, however, the other Brahmins, "from fear of pollution" (*aśucibhayād*), threw him out and abandoned him. It is only the Buddhist monks Śāriputra and Maudgalyāyana who,

[103] Chattopadhyaya 1977: 197.
[104] Ibid. 204.

> when they chanced upon him, "cleaned him with a bamboo brush, rubbed him with white earth, and bathed him."[105]

Indeed, that the Buddhists promote themselves as caregivers of Brahmins is highly suggestive of the Buddhist recognition of, and reaction to, the effects of *Dharmasūtra* and *Dharmaśāstra* laws leading to tensions at the intersection of monastic and secular laws. As Schopen rightly points out, the MSV is uniquely suited as a source for the study of India, as it "reveals a monastic community preoccupied with the separation of church and state, a community in the thick of negotiating their boundaries."[106] I argue that the relationship between early Indian monastics and the Brahmanical rejection of medicine, as portrayed in the MSV, is the result of such a negotiation.

The account of Jīvaka's biography in particular highlights how the authors/redactors of the MSV confronted this negotiation process by rationalizing the acceptance of a physician (and subsequent laws permitting medical practice) by the sangha, and circumventing criticism derived from secular law. Indeed, at first glance, the sanctification of Jīvaka, a high-standing physician, by the authors/redactors of the early *vinaya* traditions appears anomalous against the backdrop of a social and political system that rejects the medical vocation. However, the MSV is no stranger to the provision of care by monks for some members of the laity. As Schopen states, "The theme of attending to the sick and dying is, by the way, a common one in the *Mūlasarvāstivāda-vinaya*,"[107] especially when it is financially beneficial to the sangha.

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[105] Schopen 2000: 94–95.
[106] Schopen 1995: 122.
[107] Ibid. 109.

The public image of the sangha played an important role in the reception of Buddhist monks by the lay community. As outlined above, medical practice highlights a particular contention between monastic law (*vinaya*) and secular law (*Dharmasūtra* and *Dharmaśāstra* codes) in ancient India: that of the necessity for monastics to receive food donations from the laity. That the MSV instructs monastics to engage with medical practice in such a way as to avoid lay confusion between physicians and monks who practice medicine, is not surprising considering the aforementioned examples that caution the laity against the trading of foodstuffs with physicians. As Demièville (trans. Tatz) writes:

> The *MSV* T 1451: 24: 327c authorizes monks who are competent in medicine to administer sedatives, at least, to their confreres, in cases where those confreres are stricken by acute pain and no physician is at had [sic] for emergency relief. This treatment should be effected in secret, without the knowledge of laics: the monk who publicly administered a medicament to another monks [sic] would render himself guilty of a misdeed. The same *vinaya* (ibid.) on the other hand permits physician monks to give pharmaceuticals and dietetic advice to laics who come to consult them.[108]

The evident concern for monastic medical practice to remain discreet amongst the wider lay community suggests that the authors/redactors of the MSV were concerned with the negotiation of the boundaries of medical practice within a dominantly Brahmanical milieu.

[108] Demièville (trans. Tatz) 1985: 38.

The MSV account of the biography of Jīvaka is another such example. Without risking losing face amongst the laity, the authors/redactors of the MSV frame the Buddhist relationship with medicine as distinct from that of the physician. When compared against other versions of the Jīvaka biography such as that of the Pāli *Vinayapiṭaka*, the MSV account of this story uniquely presents Jīvaka in a less positive light. As such, I argue that the presentation of Jīvaka's biography in the MSV may represent the result of one way in which early Indian Buddhists attempted to reconcile monastic medical practice with the Brahmanical denigration of physicians.

The alleged son of King Bimbisāra, Jīvaka is said to have provided medical care to the king, as well as to the Buddha himself in times of sickness. The account of Jīvaka's biography most commonly employed by scholars is derived from translations of the Pāli *Vinayapiṭaka*. Yet this Theravādin source is a much shorter version than the story contained in the MSV. By looking at the MSV account in addition to the Pāli account of Jīvaka's biography, we will see that the authors/redactors of the MSV express different concerns than we can glean from the Pāli source.

Situated at the beginning of the *Cīvaravastu* in the MSV,[109] the story of Jīvaka ultimately gives way to a series of rules, established by the Buddha, instructing how monastics are to dress. To summarize, Jīvaka is born as the son of a merchant's wife and King Bimbisāra. The merchant's wife sends the baby to the King, who gives him the name Jīvaka Kumārabhṛta, and enjoins prince Abhaya to raise the baby.[110] Because of his royal status, Jīvaka must become skilled in a craft, and chooses to learn medicine. He

[109] Dutt 1942–1950, III.2: 1–148. For the biography of Jīvaka, see pp. 23–48.
[110] Ibid. 23–25.

excels under the instruction of his teacher, and offers a variety of cures to the laity. These cures include head surgery, bowel surgery, and treatments for head diseases and jaundice.[111] Because of his high achievements, King Bimbisāra proclaims Jīvaka to be a "medicine king"[112] three times over.[113]

Von Schiefner translates the beginning of Jīvaka's biography from the MSV tradition preserved in Tibetan into English, but his translation ends when the king proclaims Jīvaka to be a medicine king. Using Jinananda Bhikkhu's summary of, and commentary on, the MSV preserved in Sanskrit,[114] as well as my own translation from the MSV preserved in Sanskrit,[115] I will demonstrate how monastic concerns about the interactions between Indian Buddhist monasticism, medicine, and secular law are expressed in Jīvaka's biography.

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[111] Dutt 1942–1950, III.2. For head surgery, see p. 33.11 and p. 38.15; for bowel surgery, see p. 40.13. Interestingly, the MSV pays significant attention to Jīvaka's ability to perform surgery, a type of medical practice not typically attributed to monk-healers in the *vinaya*.

[112] Jinananda (1953: 82) chooses the translation of "royal physician" instead of "medicine king." However, as will be discussed in Chapter 3, the term "royal physician" more likely refers to a surgeon, rather than an accomplished physician who attends to royalty or the Buddha. For further explanation, see Chapter 3, or Chakravarti and Rey 2011: 29 n.33.

[113] Dutt 1942–1950, III.2: 26–43. For the first proclamation, see p. 40.1; for the second proclamation, see p. 41.20; for the third proclamation, see p. 43.16. For von Schiefner's account of this story, see von Schiefner 1906: 75–109.

[114] This translation is found in section IIa of Jinananada's (1953) doctoral dissertation at the School of Oriental and African Studies, entitled "A Study of the Pāli Vinaya Mahāvagga in Comparison with the Corresponding Sections of the Gilgit Manuscripts". For Jīvaka's biography, see pp. 41–83, and for Jīvaka's role in establishing rules for monastic dress, see pp. 84–85.

[115] I am translating from Dutt's (1942–1950) edition of the MSV found in the *Gilgit Manuscripts*, transliterated into the Devanagari script. The *Cīvaravastu* is found in volume three, part two, and the page numbers I give correspond to Dutt's page numbers.

This Jīvaka biography[116] picks up where von Schiefner leaves off, and demonstrates a strategy employed by Buddhists to redefine the physician by subsuming Jīvaka under the teachings of the Buddhist tradition, and the power of the Buddha. After Jīvaka is declared to be a medicine king (*vaidyarājā*[117]), the author/redactors of the MSV characterize Jīvaka with an inflated ego. As recorded in the MSV:

> Thereupon, [after the third proclamation] Jīvaka became arrogant, [thinking]: "There is no doctor whosoever that is equal to me. [Just as] I am the foremost among physicians of the body, so too is the Blessed One foremost among physicians of the mind."
>
> *tato jīvakasya mada utpannaḥ / na mayā samaḥ kaścid vaidyo 'sti /*
>
> *ahaṃ kāyacikitsakānām agraḥ / bhagavān api cittacikitsakānām agra iti /*[118]

This section of the story is significant; the Buddha takes note of Jīvaka's arrogance that arises after Jīvaka is dubbed a medicine king three times. While there is hardly anything negative about Jīvaka in the Pāli *Vinayapiṭaka*, the MSV transmits an image of a prideful physician. Jinananda comments on the uniqueness of the MSV's presentation of Jīvaka with an inflated ego, noting, "[this] story is not found in Mvg. [the Pāli Mahāvagga], but we quote it [here] as an example of the Gms.' [Gilgit Manuscripts'] tendency to invest the Buddha with supreme powers."[119] This difference between the Pāli and Sanskrit/Tibetan accounts is not surprising, considering the Brahmanical rejection of

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[116] Translations and paraphrasing of this story are based on my own translation of the Jīvaka biography, informed by Jinananda's commentary as well as my own translation from the Tibetan account.
[117] Dutt 1942–1950, III.2: 43.
[118] Ibid. 44.
[119] Jinananda 1953: 82.

physicians, further suggesting that the Pāli *Vinayapiṭaka* was not in dialogue with this Brahmanic milieu. Indeed, the characterization of Jīvaka as a flawed physician not only aligns with lay understandings of the medical vocation, but also presents an opportunity for the authors/redactors of the MSV to provide an Indian Buddhist solution.

The story continues as Jīvaka, because of his arrogance and pride (*madāvalepena*[120]), is unable to realize certain truths (*satyāni*[121]). The Buddha takes notice of Jīvaka's inability to realize these truths, and decides that Jīvaka's arrogant attitude ought to be handled. And so, the Buddha shows Jīvaka the Himalayan mountains (*himavatparvatarājaḥ*, lit. "snowy king of mountains"[122]), and introduces him to numerous types of medicinal herbs (*oṣadhīḥ*[123]), again demonstrating the superior abilities of the Buddha. Here, the authors/redactors of the MSV mark a shift in the dynamic of Jīvaka's biography: Jīvaka is not an all-knowing physician.

That the Buddha knows medicine is not surprising; he is, after all, omniscient. However, it is significant that the authors/redactors of the MSV explicitly defame Jīvaka's status as a worldly physician, making clear that the Buddha and his teachings remain superior to the medical vocation. The story continues, as the Buddha instructs Jīvaka further:

> Then the Blessed One addresses Jīvaka, the medicine king, "Jīvaka, possessed of four qualities is a physician, a surgeon, who is worthy of a king, suitable for a king, and to be reckoned as an attendant for a king."

[120] Dutt 1942–1950, III.2: 44.1.
[121] Ibid. 44.4.
[122] Ibid. 44.9.
[123] Ibid. 44.14.

> *tatra bhagavān jīvakaṃ vaidyarājam āmantrayate / caturbhir jīvakāṅgaiḥ samanvāgato bhiṣak śalyāhartā rājārhaś ca bhavati rājayogyaś ca rājāṅgatve ca saṃkhyāṃ gacchati /*[124]

In a question-and-answer style, Jīvaka continues to receive teachings from the Buddha. The Buddha goes on to ask rhetorically, "with which four [qualities] is a physician, a surgeon, possessed?" (*katamaiś caturbhir iha bhiṣak śalyāhartā /*[125]). He lists:

> He is skilled in disease, skilled in symptoms of disease, skilled in the removal of arisen disease, skilled in the non-production [of disease] after its removal.
> *ābādhasamutthānakuśalaś ca / utpannasyābādhasya prahāṇakuśalaḥ / prahīṇasyāyatyām anutpādakuśalaḥ /*[126]

With regards to the knowledge of the causes of disease (*ābādhasamutthāna*[127]), the Buddha emphasizes the importance of learning about diseases consisting of wind symptoms (*vātasamuttha*), bile symptoms (*pittasamuttha*), and phlegm symptoms (*śleṣmasamuttha*).[128] Wind, bile, and phlegm are the three humors that make up the tri-*doṣa* theory, or theory of the three humors,[129] one of the foundational teachings of major Āyurvedic medical works, such as the *Caraka-saṃhitā* and the *Suśruta-saṃhitā*.[130] Here we begin to see the first step in the MSV's reframing of worldly medicine as a part of the vast storehouse of knowledge of the Buddha. However, although the Buddha

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[124] Ibid. 44.19–45.2.
[125] Ibid. 45.2.
[126] Ibid. 45.3.
[127] Ibid.
[128] Ibid. 45.8.
[129] Wujastyk 1998: xvii–xviii.
[130] For example, for the tri-*doṣa* theory in the *Caraka-saṃhitā*, see "On Breath and Wind" pp. 74–75 in Wujastyk (1998).

demonstrates this superior medical knowledge, he does not actually practice medicine, thereby maintaining the ritual purity that Brahmanical law deems lacking in worldly physicians.

After answering Jīvaka's questions about each of the four qualities of a physician-surgeon, Jīvaka's arrogance fades, and the Buddha deems him ready to receive further teaching. He instructs Jīvaka on the Four Noble Truths (*āryasatya*), ultimately claiming that no medicine of a physician-surgeon can alleviate the suffering (*duḥkha*) caused by old age, sickness, and death.[131] Herein, a major distinction between worldly medicine and Buddhist ideology becomes apparent: that the solution to escaping suffering caused by old age, sickness, and death is found in the ultimate form of medicine – the *dharma*.

The recognition of the uselessness of worldly medicine for the perennial issues that drive Buddhist ontology makes it clear that the Buddha is not promoting worldly medicine as a superior form of knowledge. Rather, he subjugates the ability of worldly medicine to ease physical ailments under the efficacy of Buddhist approaches to escape suffering. And so, Jīvaka becomes a Buddhist follower (*upāsaka*), and goes on to cure ailments of kings and even the Buddha, himself.[132] Thus, Jīvaka regains his status as a superior being not because of his knowledge in medicine, but because he has realized the dharma and declared himself a follower of the Buddha. Yet his submission to the teachings of the Buddha notably precedes the acceptance of this physician by the monastic community. By acknowledging Jīvaka's high status due to his understanding of the dharma rather than worldly medicines, the MSV does not confront the Brahmanical

[131] Dutt 1942–1950, III.2: 46.
[132] Ibid. 46–47.

denigration of the medical vocation head-on, but circumvents lay criticism of monastics who practice medicine.

This conversation between Jīvaka and the Buddha is not contained in the Pāli *Vinayapiṭaka*, which jumps from Jīvaka's medical education to his worldly practice. Yet in the MSV, Jīvaka's demonstration of medical skills follows his decision to become a Buddhist follower. By calling into question the utility of medicine rather than those who practice it, the authors/redactors of the MSV are able to make allowances for the inclusion of medical practice and medical practitioners within the Buddhist community. As will be demonstrated further in Chapter Three, medical practice is not condemned by the authors/redactors of the MSV. On the contrary, allowances for medical practice are woven throughout. Those who are knowledgeable of the dharma are given a pass to practice medicine, albeit discreetly. Furthermore, room is created for physicians to become lay patrons of the sangha to provide both medical and financial assistance to the monastic community.

The MSV account of Jīvaka's biography demonstrates, at least in part, a monastic concern to maintain a positive public image in early Indian society. The authors/redactors of the MSV likely felt compelled to address the relationship between early Indian Buddhist monks and medicine due to preexisting concerns of the Brahmanical society in which they lived. Condemnations of physicians and medical practice in Brahmanical laws created a unique opportunity for the authors/redactors of *vinaya* codes to gain social and economic capital by accepting medicine and medical practice as part of Buddhist life. However, this process required the authors/redactors of the MSV to maneuver

strategically across the terrain of a society dominated by Brahmin ideologies that continued to reject the medical vocation, likely even after the turn of the Common Era.

As demonstrated by the MSV, conceptions of a Buddhist medical tradition cannot be characterized by lists of medicaments found in *vinaya* laws, as Zysk suggests.[133] Rather, the authors/redactors of early Indian *vinaya* literature strategically reframed the relationship between monks and medicine by subsuming the efficacy of medical treatment under the power of the dharma. I believe the marked delineation of physicians from monks who practice medicine, as demonstrated throughout the MSV, was a crucial step for the sangha to establish ways in which they could sidestep secular law, and benefit from providing medical care to other monks, as well as wealthy laity. Archaeological evidence for this positive relationship will be discussed in Chapter Three; as we will see, the Indian epigraphic record indicates that wealthy physicians became benefactors of the monastic corporation.

[133] In *Asceticism and Healing*, Zysk (1991: 30) claims that the five basic medicines, ghee, butter, honey, molasses and oil are uniquely grouped together to form the foundation of what he calls a distinct "Buddhist medical tradition."

Chapter 3

What the Doctor Ordered: Buddhism and Medicine in the Indian Epigraphical Record

In this chapter, I use the Indian epigraphic record to demonstrate how the relationship between medicine and monasticism can be explored further, particularly when put into conversation with my above discussions regarding MSV, *Dharmasūtra*, and *Dharmaśāstra* literature. In particular I consider Zysk's argument that as early monastic communities provided medical care to the laity,[134] the monastery came to function as the location where this care took place. Inscriptional sources that point to economic incentives for the provision of care indicate that scholarly ideas of early monastic hospitals uphold a romanticized view of Buddhist monks that functioned as monk-healers in early Indian society, overlooking other reasons for which early monastics may have engaged with the medical world.

This chapter consists of two sections: first, I evaluate existing scholarship that uses inscriptional sources to support the predominant, albeit questionable, argument that early Indian monasteries functioned as monastic medical centres for the laity. I contend that the scholars who uphold this argument rely too heavily on romanticized ideas of monk-healers who provide care out of pious goodwill, and interpret inscriptions according to these beliefs. I will demonstrate how such romanticized views obscure the relationship between early monasticism and medicine, leading to the oversimplification of ideas about monastic life in modern Western scholarship.

[134] Zysk 1991: 44.

Second, I look at a category of donative inscriptions recording the names of lay physicians as patrons of the monastic community in some of the earliest Indian Buddhist sites. As part of a larger inquiry led by Schopen, this section considers the utility of the study of donative inscriptions to uncover more information about the early patrons of the Buddhist community and their motivations for financially supporting the establishment of Buddhist structures. Using donative inscriptions that record the given names of physicians who donated money to the sangha, I demonstrate how the Indian epigraphical record provides, at least in part, evidentiary support for my argument that the relationship between monastics and medicine is grounded in transactions that occurred between monks and medical laymen.

The Ideal of the Monk-Healer and his Hospital

While the inclusion of inscriptional evidence for the study of Buddhism and medicine is not uncommon, the tendency of contemporary scholars to focus exclusively on the Second Rock Edict of King Aśoka has resulted in the assumption that monasteries functioned as hospitals in early Indian society. This edict records the provision of public services such as medical care for the Indian populace. It reads:

> Everywhere in the dominions of King Priyadarśī, as well as in the border territories of the Choḷas, the Pāṇḍyas, the Satiyaputra, the Keralaputra pall in the southern tip of the Indian peninsula, the Ceylonese, the Yōna king named Antiochos, and those kings who are neighbors of Antiocous – everywhere

> provision has been made for two kinds of medical treatment, treatment for men and for animals.
>
> Medicinal Herbs, suitable for men and animals, have been imported and planted wherever they were not previously available. Also, where roots and fruits were lacking, they have been imported and planted.
>
> Wells have been dug and trees planted along the roads for the use of men and animals.[135]

Since the early 1900s, and especially in the past two decades, this inscription has been used as evidence for the close association between monastics and the medical world.

For example, in *Asceticism and Healing*, Zysk concludes that the Second Rock Edict of King Aśoka "suggests that the monk-healers' role of extending medical aid to the laity coincided with the spread of Buddhism during Aśoka's reign,"[136] and ultimately provided the means for the expansion of Buddhism throughout the subcontinent. To support his argument of the close association between King Aśoka and medicine in the Buddhist context, Zysk relies heavily on a particular excerpt from the 1901 work of Julius Jolly, translated from its German original into English in 1977 by C.G. Kashikar. This excerpt reads:

> King Aśoka established hospitals for men and animals (3rd century BC) and the old Buddhistic medicine of *Mahāvagga* (4th century BC?), knows the Tridoṣa, eye-ointment, nasal remedy, horn-scarifying, fermentations (*Svedana*), oils,

[135] Nikam & McKeon 1958: 64.
[136] Zysk 1991: 44.

> *Ghṛta*, lotus-stalks, myrobalans, different kinds of salt, *Asafoetida* garglings, maggots in head and even the laparotomy mentioned in the latter works; it, however, knows no metallic preparation.[137]

We see here Jolly's understanding of the Second Rock Edict through the *Mahāvagga* of the Theravādin *Vinayapiṭaka*, which is understandable considering the MSV manuscripts were then undiscovered. Although MSV materials have been accessible for nearly fifty years, Zysk's exclusive use of the Pāli *vinaya* and the Second Rock Edict of Aśoka to demonstrate an association between Buddhism and medicine incurs a number of problems.

In the introduction to his book *Managing Monks*, Jonathan Silk discusses the monastic vocation, asking, "just what obligations do monks have to the lay world?"[138] His search for a Buddhist monastic identity brings to light the question of how to use *vinaya* law codes, and other extant sources, to best study the lay-monastic relationship, without neglecting the possibility that monks occupied a wide variety of economic and administrative roles.

According to these sources, Silk argues that the existence of monastic offices promotes a lay-monastic relationship that functions as, "an opportunity for devotees to generate merit by accepting their material support from a position of spiritual purity."[139] Silk maintains that the focus of monastic service did not prioritize affairs of state or, in

[137] Jolly (trans. Kashikar) 1977: 19.
[138] Silk 2008: 4.
[139] Ibid. 7.

the case of this thesis, provision of medical care to the wider population.[140] Silk convincingly challenges Zysk's argument regarding the Second Rock Edict of Aśoka, writing, "This provision is being made by the king, which is to say by the government, and not by the monastic community or even by any individual monk."[141] Indeed, such a misunderstanding fails to acknowledge the foundation of monastic service as grounded in an economic transaction for the sangha. Nevertheless, the use of inscriptional sources such as this Edict upholds the monk-healer ideal, perpetuating an ongoing game of scholastic broken telephone that can be traced back to *Asceticism and Healing*.[142]

Since Zysk's own argument is heavily contingent on Jolly's observation, one must consider the effects of the continued reliance on Pāli sources, especially since MSV materials are now accessible. In fact, it becomes readily apparent that romanticized ideas of Indian monasticism, based on the Pāli *Vinayapiṭaka*, are all too easily perpetuated. For example, in 2004, Damien Keown cites *Asceticism and Healing*, writing:

> Aśoka's interest in medicine may have been stimulated by his conversion to Buddhism, and Buddhist monks may well have had some role to play in his "national health service" if, indeed, it involved anything more than the planting of herbs and the like. What is certain, however, is that [Aśoka's] royal endorsement of medical provision [according to the Second Rock Edict] would have provided a further stimulus to medicine in the monasteries. As Buddhism spread, moreover,

[140] Ibid.
[141] Ibid. 8–9.
[142] Zysk 1991.

> the good-will generated by the provision of medical care would doubtless have encouraged monks to develop their skills in this area.[143]

This excerpt demonstrates not only the use of the Second Rock Edict of Aśoka as evidence for the close association between medicine and monastics, but it also claims that the intention behind medical practice in the monastery boils down to "good-will." Indeed, this is a clear romanticization of early monastic life. Similarly, in 2004, Serinity Young cites *Asceticism and Healing*, writing:

> The Buddhist *Vinaya*, the rules for monks and nuns, reveals a deep interest in medicine, and by the mid-third century B.C.E. medicine was part of the course of study in Buddhist monasteries, which were extending medical care to the population at large. Over time, medical skill became an important part of Buddhist missionary activity in India and elsewhere.[144]

Here we begin to see how scholarly understandings of medicine in the monastery come to be upheld as a standard aspect of monastic life. The resulting obscuration of Buddhist thought is further conflated with scholarly conclusions for the daily life and practices of Buddhist monks in early Indian history. Also relying on *Asceticism and Healing*, in a 2013 paper, Julia Shaw suggests:

> The sangha's close relationship with agricultural improvement and water management [as written in the Second Rock Edict of Aśoka] was an important

[143] Keown 2004: 178.
[144] Young 2004: 57.

> instrument of lay patronage, but it was also closely related to Buddhism's deeper preoccupation with human suffering (*dukkha*) and the means of its alleviation.[145]

The relationship between monasticism and medicine is based on a privileged reading of Pāli *vinaya* sources, ultimately upholding an image of a monk-healer ideal grounded in the Buddhist tenet of the Noble Truth of suffering.

While the Indian epigraphic record has opened new avenues to explore the question of monastic hospitals, when looking outside of the Theravāda tradition in general, and the Pāli *Vinayapiṭaka* in particular, the scarcity of evidence – both textual and epigraphical – for the existence of monastic hospitals renders such arguments speculative, at best. This chapter will attempt to interpret existing Buddhist inscriptions that are connected to the medical world alongside early monastic law codes, *vinaya*, in order to shed light on the extent to which hospitals and the provision of medical care to the greater population played a role in early monastic life, if at all.

Monastic Hospitals Grounded in Reality

Inscriptional evidence to support claims concerning the establishment of monastic hospitals is scarce in the Indian epigraphic record. However, when read in accordance with *vinaya* materials, new possibilities for the interpretation of extant inscriptions are brought to light. For example, Tsukamoto's catalogue of Indian Buddhist inscriptions includes a very compelling, albeit partial, inscription from the 3rd century CE in

[145] Shaw 2013: 103.

Nāgārjunakoṇḍa, which reads: *...[śo]bhane vihāramukkhye vigatajvar'ālaye*,[146] "in the splendid chief monastic house, [in] the abode of feverless."[147] The inscription is located on a wall within the largest vihāra in Nāgārjunakoṇḍa.[148] Zysk contends that this inscription "suggests that a health house for the care of those suffering and recovering from fever was part of this famous monastery."[149] With regards to the same inscription, Dutt posits, "the establishment … seems to have been used as a hospital as appears from an inscription on one of the walls."[150]

While Zysk translates the compound *vigatajvar'ālaya* as "abode of the feverless," Sircar provides an alternate understanding of this inscription, based on a different understanding of this particular Sanskrit compound. He suggests:

> Some writers on Nāgārjunakoṇḍa are inclined to understand *vigatajvar-ālaya* in the sense of 'a hospital.' Of course, *vigata-jvara* may also mean 'a person recovered from fever.' But *vigata-jvar-ālaya* would then mean a sanatorium for the convalescence of such persons. It is difficult to believe in the existence of a sanatorium for housing only people recovered from fever even though there is enough evidence to prove the existence of hospitals called *śālā*, *ātura-śālā*, *puṇya-śālā or ārogya-śālā*.[151]

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[146] Tsukamoto 1996, 1: 347–348.
[147] Zysk 1991: 44–45. I am using Zysk's translation here because he has provided the most literal translation. Other translations include Dutt's (1962: 134) translation of *mukhya jvarālaya* as "Main room for sufferers from fever," but this appears to be a very liberal interpretation. Tsukamoto's (1996, 1: 347–348) translation is given in Japanese.
[148] Dutt 1962: 134.
[149] Zysk 1991: 44.
[150] Dutt 1962: 134.
[151] Sircar 1963–1964: 18.

If, in fact, this inscription refers to a monastic setting wherein those free from fever would gather, there is a stronger argument to be made for the disbarment of sick persons inside the monastery, rather than the monastery being used as a centre for healing. In light of Sircar's argument, scholarly reliance on this inscription as evidence for the existence of a monastic hospital in Nāgārjunakoṇḍa must be called into question.

Chakravarti and Rey claim that the likely urban location of this monastery at Nāgārjunakoṇḍa may serve as evidence that the aforementioned inscription refers to a public setting for healing.[152] However, also because of the urban location, it bears consideration that this building may not actually have been a monastery at all. Schopen elucidates a compelling regulation in the MSV with regards to the emptying of chamber pots by nuns, as well as a number of frame-stories showing particular concern for the conduct of nuns in urban areas. Schopen argues:

> Here we can only conclude with the observation that both the rule and the frame-stories concerning Buddhist nuns emptying their chamber pots would seem to provide – no matter how the details be nuanced – additional strong evidence that the Buddhist nuns that the authors of our monastic codes knew, or were trying to govern, lived in towns and cities, that, in short, early Buddhist nuns in India were urban nuns and, as a consequence, had their own particular problems and advantages: they were not carbon copies of the monks.[153]

[152] Chakravarti & Rey 2011: 16. In particular, they discuss that because the monastery is located near several major trade routes, it is likely that Nāgārjunakoṇḍa existed as an urban centre.
[153] Schopen 2008: 255.

The implications of Schopen's argument allow for the possibility that even if this inscription at Nāgārjunakoṇḍa refers to a centre for healing, its urban location may be the result of monastic regulations and not for the service of laity. Simply put, if the "abode of the feverless" could be a nunnery, we cannot ignore the possibility that this may suggest a private healing room for nuns and rich patrons, rather than the population at large. Indeed, from the inscription alone, one simply cannot assume that Nāgārjundkoṇḍa housed a monastic infirmary wherein monk-healers provided care to the laity.

Another inscription that Zysk uses as evidence for the monastic provision of medical services to the greater population is an inscribed sealing uncovered in Kumrahār, at a the Buddhist monastery in Pāṭaliputra, dating from around 300 to 450 CE.[154] The seal reads: *śrī ārogyavihāre bhikṣusaṅghasya* "in the auspicious health house of the monastic community."[155] Zysk contends that the monastery to which this seal refers is the same location of healing as recounted by Faxian in the following excerpt from his travel records, translated by James Legge in 1886:

> The Heads of the Vaiśya families in [the city] establish in the cities houses for dispensing charity and medicines. All the poor and destitute in the country, orphans, widowers, and childless men, maimed people and cripples, and all who are diseased, go to those houses and are provided with every kind of help, and doctors examine their diseases. They get the food and medicines which their cases

[154] Zysk 1991: 45.
[155] Ibid.

> require and are made to feel at ease; and when they are better, they go away of themselves.[156]

Faxian neither claims that these healing houses are part of a monastery at Pāṭaliputra, nor implies that those providing medical services are anything but lay physicians. However, Zysk suggests, "such a structure might have been the *ārogyavihāra* (health house) of the Buddhist monastery at Pāṭaliputra."[157] In fact, to the contrary, the healing houses to which Faxian refers appear to be provided by the laity, for the laity.

Unearthed in the same debris as the above seal, two potsherds were discovered with the inscriptions "(*ā*)*rogyavihāre*" (in the health house) on one, and "(*dha*)*nvantareḥ*" (of Dhanvantari) on the other.[158] With regards to the latter inscription, Zysk posits:

> [Dhanvantareḥ] might be the title of the physician attached to the [health house], who practiced medicine according to the surgical tradition of Dhanvantari, the divine source of the Suśruta Saṃhitā.[159]

Although Zysk may be correct in his assessment of the potsherds, it is a stretch to imply that the physician in question was a Buddhist monk, and furthermore does little to support his argument that the "health house" to which the potsherds refer functioned as a monastic hospital. Moreover, the reference to the Hindu god of medicine, Dhanvantari, if anything, points away from Buddhists altogether and instead to the beginning of the

[156] Legg (trans.) 1886: 79.
[157] Zysk 1991: 45.
[158] Ibid.
[159] Ibid.

Brahmanical condoning of the medical vocation, which may have occurred as early as the sixth or seventh century CE.[160]

When the four aforementioned inscriptions are read in conjunction with *vinaya* materials, arguments claiming that early monastic hospitals provided care for the laity become even less convincing. I argue, rather, that the placement of the inscription inside the inner walls of this monastery provides greater support for the claim that medicine was practiced by monastics, for monastics. Indeed, the inclusion of infirmaries as a part of the construction of early Indian Buddhist monasteries is attested in both archaeological and *vinaya* sources. Schopen explains how early monasteries provided a type of health insurance for those who join, as is evidenced in the MSV and other *vinaya* traditions, wherein the Buddha decrees, "Monks, apart from you, their fellow monks, those who are sick have no mother, nor father, nor other relative. As a consequence, fellow-monks must attend to one another" thereby establishing a legal precedent for a preceptor-student relationship that ensures the provision of care.[161]

The inclusion of medicines within even the earliest extant *vinaya* sources suggests that monks likely possessed a certain level of medical knowledge with which they were able to maintain basic levels of health care. However, the MSV appears to be the only extant *vinaya* in which permission is given for sick-halls or infirmaries to be built within

[160] The epigraphic record suggests that by the tenth century, Brahmanical hospitals were relatively commonplace, and Chakravarti & Rey (2011: 19) posit that this shift occurred as early as the sixth century of the Common Era. For other epigraphic examples, see Demiéville (trans. Tatz) 1985: 57; and Zysk 1991: 45.
[161] Schopen 2000: 95.

monasteries.[162] Epigraphically speaking, the identification of spaces within monasteries as infirmaries cannot be assumed to have functioned as a public hospital. In fact, just as the *vinaya* laws are written for monastic eyes and ears, so too do monastic infirmaries appear to be intended for the care of monks, by monks or even lay physicians.

For the most part, the authors/redactors of *vinaya* laws appear to have been concerned with keeping the activities of monks inside the monastery, such as medical procedures, out of the public eye. For example, as we saw earlier, Demiéville (trans. Tatz) summarizes:

> The *MSV* T1451: 24: 327c authorizes monks who are competent in medicine to administer sedatives, at least, to their confreres, in cases there those confreres are stricken by acute pain and no physician is at had [*sic*] for emergency relief. This treatment should be effected in secret, without the knowledge of laics; the monk who publicly administered a medicament to another monks [*sic*] would render himself guilty of a misdeed.[163]

Thus the practice of medicine and the provision of medical care are only seen as problematic if the public becomes aware of these services, thereby rejecting monks as impure. This anxiety is supported by Schopen's discussion of the shaven-headed householder in the MSV, as discussed in Chapter 1, wherein a loophole is established for monastics to provide care for wealthy laity, in the privacy of the monastery. Similarly, if a monastery such as Nāgārjunakoṇḍa was, in fact, used to provide care to laity, the enclosed nature of the space still suggests that such treatments were done away from the

[162] Demiéville (trans. Tatz) 1985: 54.
[163] Ibid. 38.

public eye. Whether monastic infirmaries provided care only to monastics, or both monastics and the laity, neither the partial inscription at Nāgārjunakoṇḍa nor the MSV provide any concrete evidence that this space was used to provide medical care to the population at large.

No Name, No Gain in Donative Inscriptions

While the authors/redactors of the *Mūlasarvāstivāda-vinaya* demonstrate an acute awareness of the denigration of physicians in *Dharmaśāstra* law codes, the MSV clears space for the economic benefits of medical-monastic relations. As discussed in the story of the shaven-headed householder in Chapter 1, monastics were permitted to treat wealthy laity provided that the sangha become the sole recipient of the householder's wealth, upon his passing. Beyond the MSV, a number of donative inscriptions from the Indian epigraphic record also follow this trend. As such, the second aim of this chapter is to begin to uncover further the relationship between monastics and the lay population, as evidenced by the Indian epigraphic record.

The modern study of the patronage of Buddhist sites has established, in large part, the significance of the role played by monks, nuns, and the laity in funding the construction of early Buddhist sites.[164] I will employ a lesser-referenced subcategory of donative inscriptions recording the names of lay physicians to demonstrate that the monastic institution maintained a positive relationship with the Indian medical world,

[164] Schopen 1996: 58–73. While this article looks specifically at inscriptions found at Sañchi, his observations about the utility of donative inscriptions for the study of Indian Buddhist remain relevant across archaeological sites.

largely motivated by economic concerns. These inscriptions demonstrate not only the coexistence of wealthy lay physicians and early Indian monastics, but also a close, symbiotic association between the medical and monastic communities.

Donative inscriptions indicating a close relationship between the medical and monastic communities of early Indian society paint a picture with similar incongruences: namely, as physicians are purportedly being rejected, there were at least a small number of physicians who ascertained considerable quantities of wealth who became lay supporters of the sangha. Donative inscriptions recording the names of physicians provide strong grounds to conclude that wealthy physicians were one type of patron upon which the monastic community relied. For example, a mid-third century CE inscription in a Buddhist cave at Kuḍā in Western India records:

> (1) *māmakavejiyasa vejasa Isirakhit'upāsaka*= (2) *sa putasa vejasa Somadevasa deyadhaṃmaṃ leṇaṃ* (3) *putasa ca sa Nāgasa Isirakhitasa Sivaghosasa ca* (4) *duhutuya ca Isipālitāya Pusāya Dhaṃmāya Sapāya ca* [||]
>
> The meritorious gift of a cave by the physician Somadeva, the son of the Māmakavejiya physician (Ṛishirakshita) and worshipper, Isirakhita and his (Somadeva's) sons Nāga, Isirakhita, and Sivaghosa, and his daughters Isipālitā, Pusā, Dhaṃmā, and Sapā.[165]

[165] Transliteration from Tsukamoto 1996, 1: 476–477. This inscription can also be found in Burgess 1964: 86, no. 11, plate XLV; and Lüders 1909: 111, no. 1048. The translation is from Burgess.

The Buddhist site Pitalkhorā, located in Western India, contains a number of inscriptions dated between the mid-third century BCE, and the fourth century CE. Three inscriptions found in a monastery at this site record the names of physicians as donors:

> *rājavejasa Vachīputasa Magilasa dā[nam] [//]*
>
> Gift of the royal physician Magila (or Mṛigila), the son of Vāchhī (*or* mother of the Vatsa family)

> *rājavejasa Vachiputasa [Ma]gilasa dahutu Datāya dāna[ṃ] [//]*
>
> Gift of Dattā, daughter of the royal physician Magila the son of Vāchhī (or Vātsī mother)

> *rājavejasa Vachī[putasa Ma]gilasa putasa Datakasa dāna[ṃ] [//]*
>
> Gift of Dattaka, son of the royal physician Magila the son the Vātsī (mother) [166]

Chakravarti and Rey posit that the specific denotation of the physician Magila as a royal physician may indicate that this title was reserved for surgeons, and does not necessarily imply that this particular physician was a royal attendant.[167] Additionally, an inscription found at the Kaṇheri caves, records:

> (1) *Naṇṇa-vaidya* (2) *Bhānu* (3) *Bhāskaraḥ* (4) *Bhāraviḥ* (5) *Celladeva* (6) *boppai* (7) *bhaṭṭa-Vesu Suvai Po=* (8) *hoi [//]*

[166] Transliteration from Tsukamoto 1996, 1: 523. These inscriptions are also found in Burgess 1964: 84, no. 5, plate XLIV; and Lüders 1909: 137, no. 1191.
[167] Chakravarti & Rey 2011: 29 n. 33.

> The physician (*vaidya*) Naṇṇa, Rāṇa (?). Bhāskara. Bhāravi. Chelladeva. Boppaī (*Vōpadeva*). Bhaṭṭa Khasu.[168]

From available evidence, donative inscriptions recording the names of physicians appear to be just that: inscriptions featuring the personal names of physicians and their family members, usually inscribed on the cave or item that is being donated, but without naming the gift itself.[169]

Thus, while we can assume that these inscriptions serve as records of material donations, we are unable to determine whether, for example, Somadeva donated the entire cave at Kuḍā, a part of the cave, or perhaps something within the cave that no longer exists. Facing a similar challenge, Schopen discusses the puzzling nature of inscriptions that consist largely of given names:

> Any attempt to determine how the donors themselves might have understood the value of their own records immediately encounters some curious facts … . There is little or no textual warrant for the practice of inscribing a donor's name on the object he or she has given, and what warrant there is does not seem to apply to the kind of inscriptions that have survived from most early sites.[170]

What, then, can be ascertained from donative inscriptions recording the names of lay physicians?

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[168] Transliteration from Tsukamoto 1996, 1: 414. Translation found in Lüders 1909: 101, no. 984.
[169] This makes sense considering the names of donors were likely inscribed on the gift that they donated.
[170] Schopen 1996: 62.

As is increasingly the case with inscriptional studies, there appears to be a discrepancy between popular conceptions of early monastic life based on Theravādin doctrine, and the physical evidence provided by the Indian epigraphical record. Chakravarti and Rey reflect:

> The patrons [physicians] here parted with something tangible (i.e., a portion of their resources) and received in return something intangible, in other words, prestige and status associated with donors/patrons. This is at the same time when normative treatises, like the *Manusamhita*, look down upon the physicians/healers. Thus the image of the physician in the prescriptive sources is at variance with what is apparent in inscriptions, a descriptive category of source.[171]

The assumption that donors were motivated by prestige also appears to be a romanticization of early Indian society. Considering the location of inscriptions, Schopen raises two important points of consideration: first, depending on the placement of inscriptions, it appears that most inscriptions were never intended to be seen, much less read, and so prestige cannot be the only motivating factor that would entice donors to part with their wealth.[172] Second, Schopen discusses that although a number of inscriptions at Buddhist sites are plainly visible, there still remains the question of

[171] Chakravarti & Rey 2011: 15.
[172] Schopen 1996: 63–64. Schopen discusses a large number of inscriptions written and placed within containers and hidden, as well as several inscriptions at Junnar, Kuḍā, Nāsik, and Bhājā that are both too high and too dark to be seen without the assistance of a ladder and lamp.

literacy. That is, simply because the inscriptions were seen does not mean that they were read.[173]

Schopen further elucidates that even if societies of early India were much more literate than has been previously attested, because we cannot know the linguistic competencies of the population at large, there is no way to be certain that those who could read would be able to read the scripts of early donative inscriptions.[174] Thus we are faced with the problem of discerning what we can glean from donative inscriptions, carved in some of the earliest excavated Buddhist sites, recording the names of both physicians and other lay groups. Again, Schopen explains the complexities of this issue:

> [The vast majority of early Buddhist inscriptions] are carved in stone and permanently placed in proximity to a sacred object. They are, to be sure, records – they indicate who paid for the architectural piece on which they are written, but it looks as though, perhaps, a donor did not just get a permanent record. He got what may have been more important: he got, for a price, the privilege of having his name permanently in the presence of the *stūpa* of the Buddha … . A good part of these "records," then, may turn on conceptions connected with a person's name, and of those at least something is known.[175]

In sum, Schopen argues that pan-Indian ideas about the power of inscribing one's given name in stone, an action that would allow the named donor to continue to receive the meritorious benefits of his or her donation even after death, may be the force which

[173] Schopen 1996: 65.
[174] Ibid.
[175] Ibid. 70.

motivated large numbers of patrons to have their names inscribed as a record of their donation.[176] The placement of the aforementioned donative inscriptions recording the names of physicians also follows this trend; located in Buddhist caves and monasteries, the mere proximity of the inscriptions to meritorious sites supports Schopen's contention.

Therefore, while Zysk argues that the Brahmanical rejection of physicians resulted in the assimilation of physicians and monastics, the epigraphic record does not suggest that physicians became monastics, but rather that physicians functioned as benefactors of the monastic community. While the authors/redactors of the *Mūlasarvāstivāda-vinaya* demonstrate an acute awareness of the denigration of physicians in *Dharmaśāstra* law codes, the MSV also clearly creates space for the economic benefits of medical-monastic relations.

It is helpful here to recall Schopen's discussion of the "shaven-headed householder," summarized in Chapter One.[177] Upon the death of the shaven-headed householder, his assets are distributed throughout the monastic community that cared for him – including the acquisition of medicaments which the Buddha decreed were to be stored in a "hall suitable for the sick and used by monks who are ill."[178] Indeed, it is not medical practice proper that creates anxiety for the authors/redactors of the MSV, but the need to demarcate monastics as separate from physicians. Evidence from the aforementioned donative inscriptions supports my argument that wealthy physicians

[176] Ibid. 72.
[177] See p. 31.
[178] Schopen 2000: 100.

played at least a small role in the financial support of early monastic communities, and in return, their names were inscribed in meritorious locations.

Thus the relationship between monastics and the medical community appears to be symbiotic: as physicians, like other lay donors, acquired the meritorious benefits of donating to the sangha, so too did the monastic community benefit from ongoing donations. The monk-healer ideal, which continues to be perpetuated in modern scholarship, carries with it assumptions and romanticized ideas of monastic hospitals that provided care to the population at large, motivated by monastic generosity and a desire to end suffering in the world. Conversely, the Indian epigraphic record provides evidence that is well supported by extant *vinaya* sources, and ultimately paints an entirely different picture than the one that is presented to popular audiences by modern scholars.

While the establishment of monastic infirmaries in early Indian Buddhist history is well attested, there is little epigraphic evidence to suggest that these infirmaries functioned as centres for healing for anyone other than monks or nuns. Overall, the Indian epigraphic record suggests that the monastic institution maintained a positive relationship with wealthy lay physicians, whose names and titles are recorded in donative inscriptions throughout some of the earliest attested Buddhist sites. The tendency for these donative inscriptions to record only the given name of the physician and his family is supported by Schopen's argument that inscribing one's name affords the donors a continuous generation of merit, even after the named ones have died. Indeed, the contributions of physicians to the Buddhist community are well attested both in text, as

well as on the ground, as monastics were more than happy to exchange religious merit for the accrued wealth that such physician patrons clearly possessed.

Concluding Remarks

The popular assertion that the relationship between monasticism and medicine in early India developed because of a close association between Buddhist doctrine and the utility of medicine to alleviate the suffering of the population at large does not hold up against evidence from the MSV, such as the biography of Jīvaka and the story of the shaven-headed householder, and the Indian epigraphical record. The monk-healer ideal and oversimplification of the Indian medical tradition have resulted in the scholarly romanticization of monks and medicine in India around the turn of the Common Era, informed by the prioritizing of one school's *vinaya* laws – those of the Theravādin tradition. The economic incentives for medical knowledge and medical practice in early Buddhist monasticism are found across both the Mūlasarvāstivādin and Theravādin *vinaya* traditions, as well as the Indian epigraphic record. However, contemporary scholarship largely ignores the possibility that monastics may have been more concerned with wealth than the provision of medical care out of pious goodwill, as the monk-healer ideal suggests.

This thesis argued that the authors/redactors were motivated by the economic incentives that arose from a positive association between monastics and the medical world. Such incentives are evident in the MSV, which records monastic medical knowledge and allowances for the treatment of wealthy laity, as well as the Indian epigraphical record, which records the name of lay physicians who donated their wealth to the monastic community. However, early Indian Buddhists had to navigate a social and religious terrain that denigrated medical practice, thus requiring that the

authors/redactors of the MSV consider how best to engage with the medical world, without risking the public image of the sangha.

This thesis began with an assessment of Zysk's work, *Asceticism and Healing*, considering the ways in which medicine and medical practice are characterized in the Pāli *vinaya* as well as extant Sanskrit sources such as the MSV. Zysk argues that monastic medical practice contributed to the rise and spread of Buddhism, and the lay-monastic relationship came to be dependent upon the provision of care by monks for the laity. Yet neither the Pāli canon nor the MSV support these claims. Rather, the relationship between monastics and medicine is characterized as a service that is provided by monks, for monks, or by monks for wealthy laity, as we saw in the case of the shaven-headed householder.

Because of the influence of *Dharmaśāstra* and *Dharmasūtra* laws on the social, political, and religious landscape of India before the rise of Buddhism, Chapter two discussed how Mūlasarvāstivādin monks were forced to reconcile the denigration of physicians by the dominant Brahmanical class with the economic utility of medicine for the Buddhist corporation. I demonstrated how the authors/redactors of Brahmanical jurisprudence caution the wider population against giving or receiving food for physicians by characterizing the practice of medicine as a sin, and physicians as impure and unfit for participation in rites of sacrifice. Due to the monastic reliance on lay donations of food and material goods, the authors/redactors of the MSV strategically included loopholes in their law codes to create legal space for monks to take advantage of opportunities for the procurement of donations from rich laity.

In chapter two, I continued to demonstrate that based on the MSV, the authors/redactors focus on maintaining a positive public image of the sangha by clearly demarcating monks from physicians, without codifying that monks must not engage in medical practice. One such way that the MSV makes space for a positive relationship with the medical world is through the biography of Jīvaka. Found in the MSV account of this story but not the Theravādin, the legitimacy of the famed physician Jīvaka is called into question through the words of the Buddha, subsuming the efficacy of worldly medicine to the ultimate power of the Buddhist dharma.

In my third and final chapter, I turned to the Indian epigraphical record in order to demonstrate how inscriptional evidence supports my argument that monastic-medical relations were economically beneficial for early monastic communities. I discussed the ways in which Western romanticizations of monasticism and the Indian medical tradition colour scholarly understandings of inscriptional evidence. Problematically, when read alongside the Pāli *Vinayapiṭaka*, inscriptions are used to uphold monk-healer ideals, conveying an image of monastic health care that was extended to the population at large. I read these same inscriptions against MSV narratives, arguing that Indian epigraphy also conveys incongruences with contemporary scholarship that relies solely on Pāli sources.

I also used the Indian epigraphic record to support my argument that economic incentives underlie and motivate the relationship between monasticism and medicine. Indeed, maintaining a positive relationship with physicians was beneficial to the sangha, as evidenced by the number of inscriptions recording the names of wealthy physicians who patronized the sangha. The lay-monastic relationship was thereby manifested

through the ability of monks to uphold a positive public image of the sangha, while also maintaining a positive relationship with the Indian medical world that sponsored the rise and spread of Buddhism in India, at least to some extent.

Notes for Further Study

This thesis but scratches the surface of the relationship between Indian monasticism and medicine. However, I aimed to bring to light some of the issues complicating contemporary studies of monasticism and medicine, specifically those derived from a scholarly overreliance on one school's account, that of the Theravādin tradition. As Clarke notes, the Modern Western understanding of Buddhist monasticisms,

> stems from selective reading within the corpus of privileged traditions and genres, a selectivity guided by preconceived notions about what Buddhist monasticisms should look like and perhaps also by how they have been put into practice by schools of Buddhism in the modern world.[179]

As such, the study of ancient Indian history, whether religious or medical, is best conducted through the consultation of a wide number of sources. Because I was unable to consult the MSV accounts preserved in Chinese, my research was necessarily restricted to the Sanskrit and Tibetan accounts. Moreover, because I focused primarily on a comparison between Theravādin and Mūlasarvāstivādin accounts, my arguments and observations cannot be deemed representative of all, or even most early Indian monasticisms.

[179] Clarke 2014: 17.

Nevertheless, underlying this thesis is the expectation that we, as scholars, have the responsibility to convey the lives of ancient people, in this case the Indian Buddhist monk, as accurately as possible. Indeed, the historical study of the relationship between Indian monasticism and medicine is, at its core, an attempt to uncover information about the people who affected, and were affected by, interactions between Buddhism and the medical world in early Indian society. By ignoring collections of extant Sanskrit materials such as the MSV in favour of the Pāli canon, not only do romanticizations of monasticism and medicine persist in Western scholarship, but an incomplete picture of the lives of Indian Buddhist monks is also conveyed to contemporary audiences. In our case, assuming that the lives of monks were led out of pious goodwill ignores the diversity of forces such as economics that drove the development of Indian Buddhist monasticism. Just as the utility of the Pāli canon for the study of India has been called into question, it is my hope that this thesis contributes to an ongoing academic dialogue that encourages scholars to continue to untangle Western understandings of Indian Buddhist life as it relates to the Indian medical world.

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Appendix – *Instances of Sick Monks and Medicine in* The Book of the Discipline, *by I.B. Horner*

Volume	**Page nos.**	**Narrative Summary**
I	133	Description of the five basic medicines: ghee, fresh butter, oil, honey, and molasses. Explanation of offences involving the use of medicine if it results in a death.
	143–144	Six monks become ill, and the monks try and take action. They rub the first, bathe the second, anoint the third with oil, make the fourth get up, make the fifth one lie down, and give the sixth one food and drink. All six monks die, and grave offences are incurred in all situations.
	144	A woman asks a monk to prepare an abortive treatment, he does and the child dies. The monk incurs an offense involving defeat.
	145	A woman asks a monk to give her medicine for fertility. He does, and she dies. A woman asks a monk to give her medicine for contraception. He does and she dies. Both monks incur offences of wrongdoing.
II	13–15	A monk becomes ill and is allowed to go stay with his relatives to receive care. He is allowed to travel without his rug and three robes at the discretion of the sangha
	80	A monk is ill and is allowed to go to his relatives to receive care. He cannot finish making his rug so he is allowed to be lent a rug to use while he is away and ill.
	131–132	Monks can use and store medicines for a maximum of seven days
	177	All diseases are identified as "low," except for diabetes (*madhumeha*) which is "high"
	278	An ill nun is one who is unable to go for exhortation or communion
	318	A monk can eat an out-of-turn meal if he is sick
	341	The five medicines, when not being used as medicines, are considered to be "sumptuous foods"
	341–342	Monks can consume "sumptuous foods" i.e. The five medicines, if they are ill
	399	Sick monks are allowed to kindle fires for warmth
	402-403	Sick monks are allowed to bathe more frequently than the allotted two-week interval period
III	113	A monk who is ill "is not able to walk for alms"
	97–98	An itch-cloth must be measured properly for each monk
IV	89–90	five diseases are prevalent in Magadha (leprosy, boils,

		eczema, consumption and epilepsy) and monks take care of many ill monks by requesting to the public to give food to the sick (monks), give food to those (monks) who care for the sick (monks) and give medicines for the sick monks.
	91	the Buddha proclaims that a monk sick with one of the five diseases (leprosy, boils, eczema, consumption and epilepsy) are not allowed to go forth
	117–118	the Buddha permits a monk to live independently if he is ill and not receiving guidance.
	155	an ill monk is not allowed to sweep the observance-hall
	269	The Buddha allows medicines for monks in addition to the five medicines
	270–271	The use of tallows as medicine is permitted
	271	The use of roots as medicine is permitted
	271–272	The use of what was pounded off roots to be used as medicine is permitted
	272	The use of astringent decoctions as medicine is permitted
	272	The use of leaves as medicine is permitted
	272–273	The use of fruits as medicine is permitted
	273	The use of resins as medicine is permitted
	273	The use of salts as medicine is permitted
	274	A monk is afflicted with thick scabs. The buddha allows chunams as medicine for the treatment of: itch, small boil, running sore, thick scabs, bad smells. If not ill, then use dung, clay, boiled colouring matter.
	274	A chunam sifter and cloth sifter is permitted for sifting chunams as medicine
	274	The consumption of raw flesh and blood is permitted for the treatment of non-human afflictions
	275	The use of ointments is permitted as medicine. The use of ointment powders is also permitted.
	275–276	The use of ointment boxes by monks is permitted. Also lids for the boxes and ointment sticks for the application of ointments
	277	Steps for treatment for a headache: small bit of oil; treatment through the nose; use of a nose-spoon; use of a double nose-spoon; inhale steam with a tube
	278–279	A monk is afflicted by wind. The following are permitted: drinking oil mixed with strong drink, vessels for drinking, sweating by the use of herbs, a great sweating treatment, hemp-water, use of a water-vat
	279	A monk is afflicted by rheumatism in the joints. The following are permitted: blood letting, cupping with a horn,

		the use of an unguent for the feet, the preparation of foot salve, treatment for boils with a lancet, cleansing with astringent water, the use of sesamum paste. Because of the boils, the Buddha continues to permit: the use of a compress, a piece of cloth to tie over the sore, the use of mustard powder to ease the itching, fumigation to clean an infection, cut it off with a salt crystal, oil to ease the sore, ultimately the Buddha allows for a linen bandage and "every treatment for curing a sore"
	280	A monk is afflicted by snakebite. The Buddha permits the use of a decoction of dung, urine, ashes and clay
	280	A monk is afflicted by poison. It is permitted to drink a concoction of dung as medicine
	280	The Buddha permits the use of raw lye drink for the treatment of constipation
	280	The Buddha permits the use of urine and yellow myrobalan for the treatment of jaundice
	281	The Buddha permits the use of perfume-paste for the treatment of skin disease
	281	A monk is afflicted by bad humors. The Buddha permits for treatment: a purgative drink, clarified conjey, unprepared broth, prepared broth, meat broth
	286	A monk afflicted with wind in the stomach drank salted sour gruel and was healed. The Buddha permits the consumption of sour gruel as medicine.
	295–295	A monk is ill from consuming a purgative and requires meat broth. A laywoman, unable to find meat already butchered, serves him broth made from her own flesh.
	308	The Buddha permits the consumption of sugar by those who are ill, and sugar water for those who are not ill
	329	The Buddha permits a holding place to be used for medicines (allowed medicines)
	432	The Buddha declares "whoever, monks, should tend me, he should tend the sick"
V	161	The Buddha allows for medicines to be carried in a separate bag (as opposed to loose in the bowl)
	164	Monks eat a variety of sumptuous foods and become afflicted with bad humours. Jīvaka suggested to the Buddha that the monks need a place to pace up and down, as well as a bathroom
	188	The Buddha permits the use of bandages, as well as the equipment and materials for monks to make bandages
	231	The Buddha proclaims that monks cannot turn away ill

		monks seeking help. The group of 6 takes advantage of this rule and took the best sleeping places. The Buddha declares that ill monks require suitable sleeping places.
VI	54	Medicines cannot be stored for more than seven days