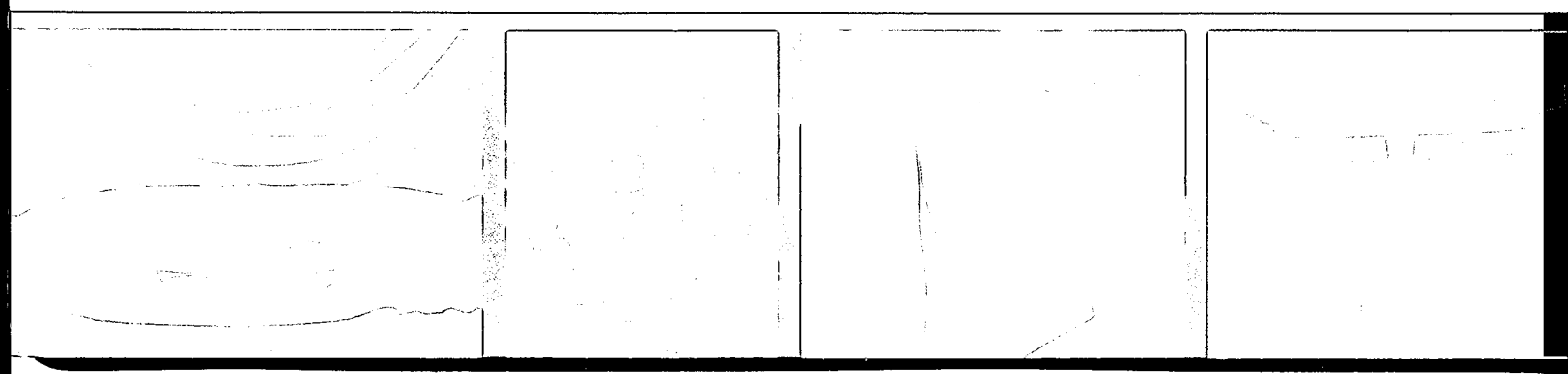
JOURNAL OF RITUAL STUDIES

VOLUME 29 • NUMBER 2 • 2015

ARTICLES



Unpuzzling an Aporia: Theorizing Acts of Ritual and Medicine in South India

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Abstract

Examining a procedure at a clinic of traditionally trained physicians of Āyurveda in Kerala, south India, this article unpuzzles the ostensible aporia separating ritual activity and medical activity. It first considers the historical and theoretical positions of "ritual" as an analytic category in the academic fields of religious studies and medical studies. Then, drawing on field data from south India, it adumbrates a practice-oriented definition of ritual that is amenable to the task of explaining human activities and interactions across cultural domains and institutions, including, though not limited to, both medicine and religion.

Abbreviations
Skt. = Sanskrit
Mal. = Malayalam

I. Introduction

For the medical anthropologist-cum-anthropologist of religion, reflection on acts of the ritualist vis-à-vis acts of the physician presents an exciting aporetic puzzle.[1] This puzzle is anchored to a frequently perceived difference of purpose and performance in the cultural institutions of religion, where scholars often position the ritualist, and science, where we generally find the physician. I revisit this distinction in what follows. Examining a clinical procedure performed by physicians of an indigenous medical system of India, Āyurveda, I explain that the idioms of ritual and medicine converge on the matter of healing, and the language used to show this convergence need not have recourse to any one cultural domain. To position the ethnography I analyze here, which is drawn from my fieldwork in Kerala, I explore ritual theory in analyses of religious and medical institutions and practitioners. I ask, for example, why analyses of so-called medical rituals regularly draw on theory and language from the field of religious studies to describe medical acts as rituals or ritualistic. Is this borrowing conducive to describing the physician's ambit of practice? Does the appropriation of language and theories from the academic study of religion help to resolve the aporia that positions the activities of the ritualist and the physician as radically distinct? Or does it perhaps perpetuate another enduring assumption that pervades, often without critique, religious studies scholarship and its allied subfields (e.g., anthropology of religion, history of religion, psychology of religion, and sociology of religion): namely, that the identification of ritual implies a religious context?

The present article looks at the history of the association of ritual with religion, and it interrogates the presumed exclusivity of this bond by delineating ritual in a medical context. As Andrew Strathern and Pamela Stewart have correctly noted, "it is in the sphere of ritual that most questions arise regarding traditional medicine." Here I argue that a longstanding and now almost natural association of ritual with religion has made it difficult for medical practitioners to perceive rituals in their practice, routinely claiming they are "superstitious nonsense" instead of seeing rituals as performing "valuable therapeutic functions where there are psychosomatic aspects of illness" (Strathern and Stewart 2010,[1] 106). I attempt to move the discussion of ritual out from under the roomy umbrella of the academic study of religion, where the category "ritual" is routinely deployed with little reflective consideration of the connotative and theoretical work it does. The presumption that religion in some way subtends ritual activity has had the unhelpful consequence of perpetuating the view that ritual acts are irrational and hence nonscientific, insofar as they are linked to something transcendent for their efficacy. In the medical context, this association tends to be abhorrent to physicians and scientists, who generally insist that their work is grounded on verifiable laws of cause and effect.

After reviewing some representations of ritual in religious studies and the social scientific study of medicine, below I develop a practice-oriented definition of ritual that is both flexible and amenable to the task of making sense of activities and interpersonal interactions across multiple spheres of human culture. Religion is of course a part of human culture, and the components of ritual I

adduce and describe can be helpful to understand elements of religious practice and performance. That said, I introduce and analyze a healing practice in Āyurveda in an effort to upset the presumption of ritual's provenance in religion. Though I do not deny that there are rituals in religion, I want to display a clear distinction between ritual and religion. This distinction, some might observe, is not new to the discipline of anthropology (as will be clear from my survey of scholarship on ritual below). But in the field of religious studies the distinction is rarely made. I contend that there are clear historical reasons for this, and I trace some of the foundational theorists over the past century who formed and fixed the connection of ritual and religion that persists in a lot of writing about religion today.

In deploying an example of ritual from a medical context, I aim to show that ritual per se carries power and meaning that is not necessarily tied to religion. The ayurvedic case study serves as a foil, in a sense, in order to illuminate the relevance of ritual as an analytic category beyond the cultural institution of religion and the purview of religious studies. The problem at hand thus is not necessarily a circumstance of parallel medical systems or rival arenas of "medical pluralism" (Strathern and Stewart 2010, 97–114).[2] Medical anthropological research can enlighten the study of ritual in religious studies, and perhaps even encourage a more mindful approach to the use of ritual in the academic study of religion. Anthropological scrutiny of a "traditional medicine"—a label that conveys intangible notions of spirituality and holism versus the empirical science of modern establishment biomedicine (for example, Āyurveda has historically been known as "Hindu Medicine")—that is grounded in practice and performance theory can illumine human interaction and activity in multiple cultural domains, including religion, where it is often presumed that the ritualist and rituals naturally belong. To illustrate this, I eschew language endemic to religious studies, language that historically has been tied to dichotomous universals like sacred-profane, otherworldliness-thisworldliness, and good-evil. The present study is about ritual as such, the components of ritual, and what ritual expresses as an analytic term. To this end, I have been inspired in part by Kaja Finkler's study, "Sacred Healing and Biomedicine Compared" (1994), which analyzes similarities and differences between spiritualist healers and biomedical doctors in Mexico. Finkler's analysis underlines the utility of practice theory to explain ritual per se, irrespective of the cultural institution under discussion (Finkler 1994, 185—187, 188–189). Especially important to my definition of ritual here is her observation that, at bottom, rituals serve to resolve conflicts.

The article proceeds in the following way: in the remainder of this section I explain the background that led me to undertake this study, after which there are five parts. In Part II, I consider ritual in religious studies. In Part III, I reflect on the representation of ritual in studies of medicine. In Part IV, to explore the possibility and utility of classifying medical acts as ritual acts, I introduce a case study from my fieldwork in Kerala among "physician-scholars" of Āyurveda known as *vaidyas*, who work in the traditional setting of a *gurukula* ("family of the teacher" in both Sanskrit and Malayalam, the language of Kerala). "Mookkamangalam" is the name I use to refer to the ayurvedic gurukula in what follows.[3] Rather than looking across multiple therapeutic techniques at Mookkamangalam, to keep the discussion on point I consider a specialized treatment known in Malayalam as *oothu*, "blowing [away disease]," characteristically used to treat snakebite victims.[4] In Parts V and VI, I suggest the Mookkamangalam case demonstrates that the idioms of ritual and medicine converge on the matter of healing and performance. I arrive at a practice-oriented definition of ritual by theorizing the clinical work of Mookkamangalam's vaidyas during the procedure of oothu according to three characteristics that I propose demarcate ritual activity: sociality, ordering, and cynosure.

As I explain below, oothu is called for almost exclusively in emergency situations. While a snakebite is a fairly common occurrence in Kerala, since 2003, when I first started visiting Mookkamangalam, I have come across the practice of blowing therapy only twice. It is these two cases that I discuss below.[5] Quotidian activities at Mookkamangalam—e.g., patient examination, diagnosis, and the prescription of therapies—may also illustrate the elements of ritual I develop here. But they do so less obviously than oothu, which demands a lengthier and more pronounced set of acts to be performed than the day-to-day activities at the gurukula.

Background: The impulse to problematize the category of ritual and the question of ritual in/and medicine began early in my ethnography of Āyurveda, and in particular at the tradition's two primary institutions of education—the gurukula and the Ayurvedic College. At Ayurvedic Colleges in Kerala, for example, I met a number of physicians and students who dismissed medical training in the gurukula as impracticable. People who held this view generally rejected gurukula training for two reasons. On the one hand, they saw the gurukula as too reliant on Sanskrit sources. They acknowledged the role of the "big three" Sanskrit medical classics of Caraka, Suśruta, and Vāgbhaṭa in forming and explicating the theories that guide ayurvedic practice (*doṣa*, *rasa*, *dhātu*, *mala*, etc.). But they regarded an exclusive reliance on

these texts to be passé, especially the texts' arrangement of medical subjects, which in the modern Ayurvedic College curriculum mirror disciplines found in biomedical schools. Matthew Wolfgram has described this attitude as "the labor of school-educated Ayurveda practitioners," which "involves the mediation between Indian classical and cosmopolitan theories of the corporeal body and its pathology and treatments" (Wolfgram 2010, 163). Given the pervasiveness of English language pedagogy alongside an increasing de-emphasis of Sanskrit studies at Ayurvedic Colleges, together with the systemization of Āyurveda on the nationwide Ayurvedic College syllabus à la biomedical science, such a critique of the ayurvedic gurukula is common today.

On the other hand, a number of professors and students at Ayurvedic Colleges perceived gurukula training as overly steeped in religious ceremony and ritual, including such things as "Dhanvantari *pūjā*" ("worship" of the god of ayurvedic medicine) and recourse to religio-philosophical concepts like *karma* ("action") and *dharma* (social-legal-religious "duty") to explain why people become ill or why treatments sometimes fail. Holders of this view regarded Hindu *pūjā* and unverifiable diagnoses suggesting a person's past socio-religious indiscretions (Skt., *adharma*, "-non-dharma") might have caused disease to be unhelpful to the ayurvedic practitioner seeking to situate his or her medical practice in competitive relation to biomedical physicians. Although most of the people at Ayurvedic Colleges with whom I spoke conceded that the history of gurukula education is important to understand and appreciate the state of modern Āyurveda, when situated as an evolution from the gurukula to the college, the history of ayurvedic education tends to illuminate the pedagogical and practical distance modern Āyurveda has covered (and hence the progress it has made) from the perceived antique religious training of the gurukula. Based on arduous memorization of Sanskrit medical compendia, where accounts of health and illness might invoke astrology, social ethics, devotional practices, and dharma in addition to classical Indian analogues of anatomy and physiology, gurukula pedagogy has virtually no practical leverage over the future of medical education at Ayurvedic Colleges.

In my earlier research on storytelling as a means to relate bio-physiological issues in Sanskrit literature, I identified a clear and recurrent intersection in the ayurvedic sources and other Sanskrit genres (such as myth, epic, and drama) where bodily disease and health are handled with recourse to ethics, supernatural entities, and religious right (Cerulli 2012). I probed the apparent influence of religion and religious thought in Sanskrit medical literature and examined areas in the history of Indian religions where medical discourses offered creative articulations about important (primarily Hindu) religious doctrine, such as grounding the notion of dharma on bodily wellbeing and theorizing karma in the current moment rather future iterations of a life cycle, as a means to preserve health and prevent disease. Yet when I spoke with ayurvedic vaidyas about the use of the Sanskrit medical classics in their clinical practice, I found myself presented with still another "reading" of Āyurveda that perceived the historical ayurvedic centers of education (i.e., gurukulas) as somehow tied to religion and religious practices. Rather than originating within the literature itself, this time the perception emerged from college-educated vaidyas who suggested the gurukula used texts and deployed practices akin to religious learning and ritual acts.

Whereas the classical Sanskrit medical literature mixes an array of explanatory models to explain health and illness, portrayals of the medical gurukula by professors and students at Ayurvedic Colleges in south India tend to be fraught with a rigidity that occludes a reconciliation of the seemingly unscientific elements of the tradition with their modern college education. Nearly everyone I interviewed acknowledged that the Sanskrit sources that influence the gurukula curriculum bespeak broad and deep discernments about not only the body, but also about the entire human condition. Most interviewees also regarded the "interdisciplinarity" of ayurvedic literature (incorporating multiple knowledge systems to elaborate "long life," [Skt., *āyus*]) as part and parcel of the tradition's enduring and vital role in Indian cultural history. Nevertheless, these very same literary foundations, because they are also popularly perceived as representative of "alternative" or "complementary" approaches to healing (when juxtaposed to the prevailing biomedical establishment—the standard juxtaposition made in North America and Europe), might also be cited by critics of Āyurveda or practitioners of competing medical systems as indications of the "soft" or perhaps "spiritualized" nature of Āyurveda. This perception is viewed as problematic by college-educated vaidyas in India today. For at least four decades, since the mid-1970s when the Central Council for Indian Medicine (CCIM) ratified the common curriculum for Ayurvedic Colleges countrywide, prominent physicians and governmental committees in India have been positioning Āyurveda to compete in India itself, as well as in the global medical marketplace, alongside biomedicine. Consequently, in Ayurvedic Colleges there have been sweeping attempts, beginning in the 1890s, concretized by the CCIM in the 1970s, and continuing in the present day, to excise from the colleges' syllabi elements of gurukula education that have been perceived to intermingle classical Āyurveda's empirical "medicine" with religious and ritualistic extravagances.

My observations at medical gurukulas in south India are naturally informed by my work on religion generally and religion in India especially, and therein lies the principal rub of what follows: as I consider the theoretical development of ritual among scholars who contribute to the academic field of religious studies, I argue there has been and continues to be a tendency to use the term "ritual" as if the word possesses an explanatory power in and of itself. This use unreflectively perpetuates the notion that ritual and ritual acts (usually positioned opposite faith and doctrine) naturally belong to the domain of religion. I explain how this association came about, and I use my fieldwork at Mookkamangalam to problematize the ritual-religion link, suggesting that recourse to religion and religious language is neither the only nor the most fruitful option in bringing clarity and analytical breadth to ritual theory.

Before moving onto a discussion of ritual in the contexts of religious studies and medicine, I would like to mention briefly a central notion to which I return repeatedly throughout this study. In line with Kaja Finker's work mentioned above, the concise and flexible definition formulated by Seligman, Weller, Puett, and Simon operates as a baseline for my understanding of the components of ritual acts. Ritual, they explain, is "a unique way of accommodating the broken and often ambivalent nature of our world" (Seligman, Weller, Puett, and Simon 2008, xi). I complicate and expand this definition by suggesting, for example, that Catherine Bell's expression of ritualization and J. Z. Smith's notion of emplacement address the form of ritual and its characteristics in ways that Selgiman, et al's broadly conceived portrayal does not capture. All the same, for the moment at least, the articulation of Seligman, et al nicely evokes the three areas of sociality, ordering, and cynosure that I elaborate below. The broken and ambivalent nature of being human, at its very base, rests on the fragility and necessarily degenerative physicality of the body. Notions of health and well-being are ideals that medical systems in general, and Āyurveda is no exception here, reach for but never perfectly gain; the body is in a constant state of disintegration, however slowly and imperceptibly, and the meeting of patient and physician may be seen as a collection of intricate sensory experiences that represent "the creation of a controlled environment where the variables (i.e., the accidents) of ordinary life have been displaced *precisely* because they are felt to be so overwhelming present and powerful" (Smith 1980, 124–125, italics in the original). It is, after all, in the course of so-called ordinary life that people encounter the contagions, illnesses, fractures, and so on they bring to their doctors. Ritual acts function according to this notion of adjusting to, with the aim of correcting, fractured and uncertain states of being among individuals and their communities (Finkler 1994, 188). The medical encounter illustrates this well and makes room for further theorizing of ritual as an analytic category freed from constraints of a single disciplinary source or academic field.

II: Ritual in/and Religion

It might be the case in some, perhaps even many, circumstances that rituals are religious, linked to religion, or in some way evocative of something sacred. Although my focus in this section is on the use of ritual as a categorizing tool in religious studies, the term is equally ubiquitous in other disciplines in the modern North American university, such as anthropology, history, psychology, and sociology. Even in these latter cases, however, often religion (or an element of religion, such as sacred discourse, transcendence, divinities, etc.) is descriptively linked to the function of ritual acts, as in, for example, studies of purification, solidarity, matrimony, holidays, and so on. This might lead one to ask: Is the study of ritual inexorably bound to the context of religion?

In the late-1970s Sally F. Moore and Barbara G. Myerhoff's edited volume, *Secular Ritual* (1977), ushered in an important and novel explanation of the link between ritual and religion. Although immensely valuable for rejecting a reduction of ritual activity to the domain of religion, by making the secular the primary marker of ritual Moore and Myerhoff's book, perhaps unintentionally, ensured that religion retained pride of place in ritual theory. That is, in calling ritual secular, they (and their contributing authors) were bound to discuss ritual inside and outside of religion. When all's said and done *Secular Ritual* is helpful to understand that ritual acts can be sacred or secular, religious or nonreligious. Yet the reader is left with the sense that secular rituals can only be identified using language that does not speak of rituals as such—ritual in its own right irrespective of environment and cultural institution—but only insofar as they display the mirror opposite of acts presented in religious settings.

While definitional flexibility is vital for any analytic category to work meaningfully across disciplinary studies of human culture, my aim here is to disaggregate long-standing dichotomies like secular-sacred (as well as medicine-religion), which tend to obscure, if not deny, analytic flexibility and viability of ritual across cultural domains. To move away from dichotomous assumptions about ritual, it is vital to consider from where the foundational theoretical and methodological history that has helped to create a close connection between ritual and religion originated, and to correct past misidentifications in

ritual theory with new case studies. The secular-sacred distinction is of course only one, very narrow and ethnocentric meaning that scholars have theorized to explain religion and religious phenomena. Nearly half a century ago, for example, Clifford Geertz's famous definition projected religion as a "system of symbols" (Geertz 1973, 90), whereas a decade ago Bruce Lincoln envisioned a definition of religion as consisting of four fields: discourse, practice, community, and institution (Lincoln 2003, 5–8).[6] In religious studies, the link between ritual and religion was crystalized in the development of the secular-sacred dichotomy decades before Moore and Myerhoff pointedly addressed the opposition in 1977.

Émile Durkheim's influence in drawing ritual within the cultural sphere of religion and, thereafter, within the academic umbrella of religious studies is fundamental to this discussion. In *The Elementary Forms of the Religious Life* (1912, original French edition), Durkheim famously wrote that religion is "a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden—beliefs and practices which unite into one single moral community called a Church, all those who adhere to them" (Durkheim 1947, 47). Durkheim thought that religion was a collective, social experience, and that all aspects of people's lives in non-western societies were perceived and experienced according to a dichotomy of the sacred and the profane. Whatever one's take on Durkheim may be, when it comes to the study of ritual and religion his work is foundational, and many of the best contemporary theorists of ritual fittingly used Durkheim's work as a place of departure, expansion, and critique. To name just two of the more well known scholars of ritual theory in recent decades: though indebted to Durkheim, Catherine Bell's research sharply critiques Durkheim for overstating the religion-society equivalence; in his writings, Roy Rappaport consistently criticizes Durkheim's insistence that categories of thought derive from social forms only, rather than from within all domains of action (Stewart and Strathern 2014, 29).

Durkheim assigned the entire orbit of ritual activity within the realm of the sacred, powerfully relegating ritual to the context of religion. Rituals are acts oriented towards the sacred, he said. Nevertheless, setting aside the reductionism and cultural myopia entailed by the sacred-profane distinction he associated with ritual, if we take his description of ritual as such, which are based on analyses of photographs of Australian aborigines, Durkheim's method of explaining ritual in *The Elementary Forms* appears to anticipate what later becomes "practice theory" (Kreinath 2012).

Crucially, Durkheim saw ritual acts as existing within the actor's frame of reference. They are meaningful to the people who perform them. Talcott Parsons further developed this position, which he understood to be consistent with the Weberian notion of *Verstehen*, suggesting that ritual situations "must be subjectively defined, and the goals and values to which action is oriented must be congruent with these definitions, must, that is, have 'meaning'" (Parsons 1954, 209–210). With this formulation of ritual contexts we run into a problem: How do we adduce objective criteria to explain for whom meaning exists—for the actor, the observer, both—not to mention the content of the so-called meaning we are discussing? If the meaning is of a religious or sacred nature, then we furthermore must address questions concerning what constitutes the sacred as well as religion and, conversely, what does not.

Staying with the Durkheimian schematic that classifies rituals as actions necessarily oriented towards the sacred, and presuming that scientific activity would not fit this basic criterion, it would appear that we are left with no option but to relegate the work of biomedical professionals to the realm of the profane. Not oriented towards the so-called sacred, but rather towards strictly somatic curiosity and commitments, to compare medical acts with religious acts—for Durkheim, these are practices buttressed by beliefs that unite a group of people into one single moral community—is akin to comparing apples and oranges. They are incommensurable. In the end, the sacred-profane dichotomy, which assigns meaning to actors according to whether they orient their actions to or away from the domain of the sacred, inevitably falls short of explaining a universal human religious worldview. As Roger Caillois famously observed, "without a doubt, the profane, in relationship to the sacred, simply endows it with negative properties. The profane, in comparison, seems as poor and bereft of existence as nothingness is to being" (1959, 21–22). Caillois questioned the possibility of identifying objective criteria as either sacred or profane, sternly critiquing the utility of these categories for comparative social-scientific use. Nevertheless, others after Durkheim advocated and extended the dichotomy, most notably Mircea Eliade, who made it the centerpiece of his most popular work on the historical and comparative study of religion.[7]

All the same, the theory of ritual has offered many disciplines useful insights into the motivations and effects of peoples' actions. We would therefore throw out the baby with the bathwater if we were to abandon further theorizing of ritual as an analytic category after identifying the inutility of the sacred-profane dichotomy to our description and use of ritual. "Adequate as this [sacred-profane dichotomy] may be for theological purposes," Jack Goody observed, "it is hardly sufficient as an analytic tool of comparative sociology" (2010, 26). Given the

historical use of the term, the task of theorizing ritual in any discipline demands that one take a critical view of religion and things religious, which notably since Durkheim's sociological paradigm of religion have included ritual activity.

In Durkheim's scheme, while the occurrence of ritual activity is imbricated within the cultural domain of religion, the mean-ends relationship of ritual action is symbolic rather than intrinsic to the activity of ritual itself (Durkheim 1947, 137, 430–431).[8] Arguably even more influential than Durkheim's theorization of ritual, Marcel Mauss's synthesizing notion of "technique," which he articulated both with his uncle, Émile Durkheim (*De quelques formes primitives de classification* [1902]), and in his own works ("Les techniques du corps" [1934] and *Manuel d'Ethnographie* [1947]), powerfully swayed anthropological and sociological considerations of ritual in the first half of the twentieth century. Mauss suggested that "magic, sacrifice, sorcery, shamanistic practice and technical arts could be put together into a single category of 'techniques,'" Jean-Pierre Warnier has argued, "because all of them have *tangible effects* that can be assessed and described (Warnier 2009, 460, italics in original). Addressing the idea of technique directly, Mauss wrote: "I call technique a *traditional efficacious* act (and you can see that it is not different from the magical, religious or symbolic act" (Mauss 1934, 278, italics in the original).[9] He insisted on the dual-effect of techniques, and hence also so-called religious acts: they are transmittable by tradition and they have real-world tangible effects (Warnier 2009, 461–462). Mauss's complex work on techniques (and cultural technologies) was nonetheless outstripped in the second half of the twentieth by scholars working on the anthropology of technology like Robert Cresswell and François Sigaut, who raised materialistic questions and concerns, explicitly applying Marxist readings of productive social forces on the technical work of tradesmen, agriculturalists, and artisans (see, e.g., Cresswell 1969 and 1993; Cresswell, et al 1975; Cresswell and Godelier 1976; Sigaut 1975, 1977, 1978, 1985, and 1994). Analyses of cultural technologies moved away from the domain of ritual and religion under this focus, and many scholars' relocated their attention on means-end relationships in ritual to the targets of technologies, such as human subjects or lifeless matter.

Mauss was not completely unconcerned with ritual targets, however. He was interested in probing the ways in which people authenticate efficacy in ritual, magic, sorcery, etc. The ends of ritual activity, he argued (in collaboration with Henri Hubert), belong to a "world of ideas which imbues ritual movements and gestures with a special kind of effectiveness, quite different from their mechanical effectiveness." Ritual acts and gestures are then classified as "*traditional actions whose effectiveness is sui generis*" (Mauss 2001, 25, italics in original). This delineation leaves unanswered critical questions of adjudication: who measures efficacy and by which criteria is it measured? Do the means of ritual (or magic or sorcery) bring about this peculiar end consistent with progressions that are valid according to scientific causation? If the answer is no, the ritual practice is oftentimes taken to be irrational and/or ineffective.

Talcott Parsons nuanced the Durkheimian and Maussian demarcations of ritual, arguing that ritual acts are neither symbolic of a means-end relationship nor is the means-end relationship intrinsic to ritual practices. But in committing ritual activity to neither of these things, he did not then say that ritual practices are irrational. Instead, as Jack Goody has explained, Parsons developed a type of "action which is neither rational nor irrational ... but non-rational, or 'transcendental'; that is, it has no pragmatic end other than the very performance of the acts themselves, and cannot therefore be said either to have achieved, or not to have achieved, such an end" (Goody 1961, 154). Parsons's suggestion that ritual acts are ends in themselves is attractive and it evokes the argument Frits Staal made nearly two decades later, attempting to debunk the notion that rituals communicate symbolic meaning: "the only cultural value that rituals transmit are rituals," he famously wrote. Ritual, he continued, is "pure activity, without meaning or goal," "without function," and "for its own sake" (Staal 1979, 9). Staal's position received a fair amount of criticism—notably in two trenchant articles in the *Journal of Ritual Studies* (Thompson 1995 and Harris 1997)—on the grounds that, contra Staal, ritual does have symbolic meaning, often meaning that points to a socio-historical value system linked to the particular group engaged in the activity. Rituals communicate knowledge to the members of the so-called ritualized body. And the "rules of the ritual are," according to Solomon Harris,

> self-contained within that ritual and have no bearing on things outside that ritual. But the ritual as an entity is related to its associated group and the historico-social evolution of that group ... Thus rituals are embedded in the value system of their respective groups and serve the purpose of internalizing and perpetuating that value system, or some aspect of it. Looked at in this way, the internal rules of ritual *per se*, may in the restricted sense of "meaning" as used by Staal, be regarded as meaningless; but the ritual as an entity and as a component of the socio-cultural value system of the particlar [sic] group, is meaningful (Harris 1997, 43).

Parsons's work and the critiques of Staal's article underscore the social value and function of ritual (Harris calls

this the "we-ness" of ritual; I call it ritual's "sociality") and a reinvigorated and pointed attentiveness to the activity of the group (what I refer to as "cynosure" below). These positions did not declare ritual to be irrational or inefficacious as such. They helped to create space in which to query ritual apart from religion, in spite of the fact that so many scholars of ritual since the nineteenth century argued that the irrationality of the ritual act is what makes it religious. That said, even if ritual practice is valuable in itself, and thus nonrational, the Parsonsian theory still places ritual within the category of the actor's frame of reference, which is problematic. A ritual is nonrational, irrational, rational, or something else depending on the ability of the observer of the activity, not the actor, to perceive a connection between the means and the end.

By recognizing the value of the acts of rituals themselves, Parsons accentuated the practice and behavior of ritual activity (and, if we are generous, also the bodily basis of ritual). Nevertheless, he still foregrounded belief and understanding in his analysis. Here Evans-Pritchard's classic study of the Azande usefully warns us that there has not been ample evidence to suggest that people in non-western societies believe in universal kingdoms of belief like the sacred and the profane. For his part, Evans-Pritchard distinguished between "ritual and empirical actions by reference to their objective results and the notions associated with them" (Evans-Pritchard 1937: 463). While I do not support Parsons's proposition (or the similar argument of Staal) that ritual acts have no pragmatic ends beyond their performance, I do want to draw attention to the bodily, performative, and especially the processual activity of ritual that his analysis highlights, and then go further. Ritual actions, as I conceive them, cultivate a kind of discipline in the actor, creating "ritualized agents," as Catherine Bell called them, whose bodies subtend an instinctive knowledge, certain ideals, and dispositions that enable the achievement of desired ends (Bell 1992, 221).

A critical question in any theorization of ritual must probe how the category is being used. Does the term "ritual" carry an implicit or explicit assumption that ritual acts are causal social factors or organizing principles? Are rituals, in other words, existing processes for social actors or organizing principles that exist only for researchers? My sense is that scholars working on ritual often fall prey to the former—taking rituals as causal social factors rather than organizing principles of the observer—holding the erroneous belief that rituals, because of an inherent symbolic or expressive force, illustrate major principles of social behavior rather than merely express or signify social structures. This approach, following Goody, "simply involves the reification of an organizing abstraction into a causal factor" (Goody 1961, 157). For William Sax, this amounts to the "academic sin of reification," that is, mistaking an analytic category for a natural kind (Sax 2010, 3). By taking ritual as a concrete or real expression of social behavior, scholars, since Radcliffe-Brown, have typically defined ritual in opposition to rational and scientific acts (Radcliffe-Brown 1952, 136–139). The symbolic force of ritual is assigned from outside, by the observer, etically imposed, and declared to be integral to the actor's frame of reference in an attempt to make sense of what otherwise appears to be devoid of reason. Here again, as with the question of meaning, the matter of symbolic significance is fraught with uncertainty—symbolic for whom, the actor, the spectator, both? Working from the assumption that ritual is an analytic category of the observer, not an emic belief of the actor, we must concede that the observer assigns meaning, expresses what aspects of ritual actions are symbolic of the social structure, and so on, not the actor (who might or might not have knowledge of a symbol's reference, and very well could reject its interpretation when he hears it).[10]

Some of the activities in the medical gurukulas in Kerala where I work are strikingly similar to those described as rituals in religious studies literature. A major and unavoidable difference is this: actors at the gurukula do not engage in activities that would appear to link them to religion, divinities, or anything akin to the so-called sacred. Vaidyas at Mookkamangalam see their clinical activity in no uncertain terms as medical science (Mal., *vaidyagaṇitavuṃ* and *vaidyaśāstraṃ*); they work with and dispense medicine (*marunnu*) to promote overall health (*ārogyaṃ*). If we grant that their work is devoid of a religious component, are we then justified in discussing their practices as rituals? Must we use terminology that evokes directly or indirectly ritual theory that draws comparisons to religion and the religious to understand and describe the medicine and healing practices of gurukula vaidyas in Kerala? May we instead accurately state that the actions of these physicians fall within a category of ritual that is neither religious nor magical, that do not acknowledge the presence of supernatural entities, and for which a means-end relationship is intrinsic (such as, practices leading to health)?

III. Ritual in/and Medicine

In scholarly literature on the intersection of medicine with other domains of culture, such as economics, politics, and religion, it is not difficult to find descriptions of a visit to a doctor's office portrayed in terms of ritual theory. To take one example, in "Ritual in Western Medicine

and Its Role in Placebo Healing," John Welch suggests many points of similarity in the acts of a biomedical doctor-patient exchange and the acts of what he calls "the shaman's blend of religion and medicine." His comparison goes like this: there is a patient (the pilgrim), who travels some distance (the pilgrimage) to the doctor's office (the pilgrimage destination). Upon entering the doctor's office, the patient crosses a threshold from the mundane (profane) world into a sequestered (sacred) space, which he refers to as a temple of medicine. The patient transforms from a regular citizen into a pilgrim on this journey, and she is greeted by nurses (temple matrons), who examine and judge her, and record the details of their enquiry in her "book of life."

The change from ordinary citizen to patient is further solidified in the subsequent denuding a patient sometimes undergoes, from street clothes to austere hospital gown; nearly fully exposed, the patient-cum-pilgrim waits for the intermediary between herself (a human patient) and the gods of medicine. This go-between is the doctor, dressed in white robes, who sets the parameters of the meeting with the patient, and ultimately defines and gives meaning to the illness the patient presents. The doctor is a priestly figure, who receives the patient's report of illness (a confession); after laying his hands on the patient, using special instruments specifically for the purpose of this meeting, the doctor-cum-priest consults special texts, and ultimately pronounces the patient's condition using technical language (Welch refers to the doctor's tools, texts, and language as "sacred"). A regimen is prescribed, and it usually involves a kind of observance, perhaps involving some ointment or pharmaceuticals, and may include a set of actions to be performed. Whatever the remedy entails, it will include, Welch writes, "a reiteration of our common beliefs concerning health and illness, how we believe we maintain order and balance between the two, and a promise that the therapeutics will result in a restoration of that health and a balance between ourselves and the cosmic forces of wellness" (Welch 2003, 24). Welch presents a colorful correspondence, bordering on the parodic, between the doctor-patient encounter in biomedicine and the priest-pilgrim engagement in religious ritual. His comparison is based on a study of the use of placebos in biomedicine, suggestive of Ted Kaptchuk's recent contention that "placebo studies may be one avenue to connect biology of healing with a social science of ritual. Both placebo and ritual effects are examples of how environmental cues and learning processes activate psychobiological mechanisms of healing" (Kaptchuk 2011, 1856).

Environmental cues and processes of learning do play a role in the healing of medical patients, generally speaking, and this is also true in the gurukula settings of Kerala. But unlike Welch's study, I want to ask what happens when we read medical practice using ritual theory *without recourse to religious discourse or imagery.* If we drop this language, to put it crassly, must we drop ritual theorizing? Rituals in Welch's study clearly have an instrumental purpose. They do in the Kerala context too. But ritual purpose, while it may be religious, needn't necessarily be so. To apply ritual theory in the medical context, one often encounters a good deal of stubbornness among practitioners. "Generally, priests think they are engaged in ritual" Ronald Grimes memorably wrote, while "generally, physicians deny that they are" (Grimes 2000, 26). To use or reject ritual for these two groups of professionals usually signifies the degree to which they see their work as efficacious. Priests are effective in what they do because they have rituals that in some way help them, from their earthly positions, communicate with and on behalf of the divine. Medical practitioners (especially, but not only, in biomedicine) might reject the possibility of rituals in their practice because they view their work as utterly of this world, entirely human. For them, activities depending upon transcendent influence are unnecessary, if not irrational. A pillar of biomedical research is the rejection of any therapy that is not based on the apparatus of RCT, randomized clinical trials. Even though the doctor-patient engagement described by Welch contains supportive elements that benefit patients (aka a doctor's bedside manner), this interpersonal aspect of biomedicine is often viewed as a way to encourage obedience and prepare patients for the "real" medicine that will be prescribed later on. The ideology of biomedicine marginalizes ritual, alongside the placebo effect, where it is classified as "art" opposed to "science" (Kaptchuk 2011, 1854).

Practitioners at Mookkamangalam refer to the acts they perform that require on-the-spot preparation and distribution of medicines, acts like oothu, as a *prayogaṃ* (from Skt. prayoga). A *prayogaṃ* is a practice or application of something, a means to some end. It is typically understood in opposition to theorizing. In the context of the ayurvedic clinic, the *prayogaṃ* involves the coming together or connection (the root meaning of the Sanskrit prefix + verb, *pra* + *yuj*) of a sequence of actions that progress toward a particular goal. The components of a clinical *prayogaṃ* require a combination of skillful technique and experience. Experience here is understood to include both deep knowledge of the Sanskrit and Malayalam literature in which the actions to be performed are explained as well as years of clinical engagements with patients. The latter occasions repeated application of the former, so that a seasoned vaidya knows when and on whom to perform a therapeutic practice.

Day-to-day activities in a gurukula clinic display practices that fit within a number of useful academic defini-

tions of ritual. For instance, at different times and to varying degrees elements of Stanley Tambiah's classic definition are apparent, including formality-conventionality, stereotypy-rigidity, and redundancy-repetition (Tambiah 1985, 128). Following Sax's application of Bourdieu to Tambiah's framework, there is also embodied practice with a logic that is not reducible to linguistic expression (Sax 2010, 7–8). Special attention is given to space in which, as Richard Schechner put it, "the performance process and the ritual process ... are strictly analogous" (Schechner 1985, 193; see also Rappaport 1999, 117–119). A fascinating and somewhat problematic element of the doctor-patient encounter at Kerala gurukulas, especially from the standpoint of the observer, which I cannot discuss here for lack of space, involves what Thomas Csordas has called the internal states of the patient of ritual healing—predisposition, empowerment, and transformation (Csordas 1983). This list could go on and on.

Scholars have in the past and continue today to deploy the analytic category of ritual in radically divergent yet pointed ways. The array of emphases to which a scholar chooses to attend in her or his definition of ritual points to the variety of ways rituals may be framed, to convey the "sense of 'This is a ritual'" (Stewart and Strathern 2014, 123). The three areas of ritual I put forth below—sociality, ordering, and cynosure—contribute to a working definition of ritual in the way that Jan Snoek has suggested ritual definitions, for all of their terminological variability, tend to produce a "fuzzy set" or "polythetic class" of common characteristics (Snoek 2008, 4–5). We know a practice fits within the category of ritual when it resembles to a certain degree the elements of a given definition. Some will contain more or less of any component. But effectively when you see it, you know it. Another way of putting this is to use Wittgenstein's family-resemblance approach to category definition: though we recognize that which we are calling rituals are not all the same, we also acknowledge that rituals share certain characteristics, and, as Sax put it, "when a particular activity has a sufficient number of them, it 'counts' as ritual, more or less" (Sax 2010, 7).

Before probing the case of oothu, I would like to underscore a small but important methodological point. My aim in this paper is to explicate a basic theoretical model to use in the analysis of ethnographic data I have gathered among physicians in Kerala over the past decade. There are obvious costs to making theory the focus of study. I am after the *processual components of ritual formation and activity through which behavior patterns are modified and which serve communicative functions apart from their primary or original functions.* In short, my aim is to theorize, following Irenaus Eibl-Eibesfeldt's classic articulation, the process of ritualization (Eibl-Eibesfeldt 1970, 97). Consequently, there are aspects of oothu that I present without much interpretation, and most phenomenological considerations (e.g., Csordas's "internal states") of the patient's experience are bracketed for discussion elsewhere. The experience of the patient is important, no doubt, because it is both a part and a product of the clinical procedure. The patient is always there! And while I do discuss the patient's participation and placement in ritual, the expressed feelings of the patient concerning the healing process of oothu will be better served in the context of the larger study out of which this paper has emerged.

IV. Textual Context of Oothu

The snakebite treatment of oothu, blowing therapy, is not described in the Sanskrit medical classics of Āyurveda. The earliest mention of blowing therapy is in an old Malayalam text (written in the medieval south Indian language Maṇipravāḷam) honorifically attributed to Nārāyaṇa, the *Jyōtsnika* (*Moonlit Night—from Skt. jyautsnikā*). In this work, blowing is prescribed in cases of snake poisoning. In a modern Sanskrit work based on the *Jyōtsnika*, C.K. Namboodiri's *Viṣavaidyasārasamuccaya* (*Precious Compendium of Toxicology*), a similar account of oothu is offered. Both of these texts advise the vaidya to use oothu when confronted with a snakebite victim who exhibits one or more of a lengthy list of symptoms, including delayed response to verbal and physical stimuli, drowsiness, numbness of the tongue, vertigo, overall body ache, and excessive salivation. The technical description for the performance of oothu is very brief, amounting to just two shlokas in either work.

> After repeatedly chewing equal amounts of ginger, stinging nettle, black pepper, and Indian birthwort in the mouth, softly blow 150 times simultaneously into the two ears and onto the fontanelle of the patient. This should effectively eliminate the poison from going to the first three bodily elements (*rasa*, *rakta*, and *māṃsa*), the skin, etc.[11]

This passage offers little information about the actual work of the procedure. Most notably, who chews the plants and blows on the patient? At Mookkamangalam, the vaidyas do not blow the medicine on the patient. Attendants of the patient do this. Indeed, in the execution of oothu the vaidya is less involved in the physical performance of the procedure than the patient's medically untrained attendants (I will return to this imaginably counterintuitive aspect of oothu momentarily). The tex-

tual basis for oothu also provides very little by way of procedural rationale, that is, oothu's basis in ayurvedic theory. V.M.C.S. Namboodiri's commentary on the *Viṣavaidyasārasamuccaya* offers some insight to this end, fortunately. He links the practice of medicinal breathing to the ayurvedic theories of a body's "vulnerable spots" (Skt., *marmans*) and "humors" (Skt., *doṣas*).

The body's vulnerable spots are associated with the vascular system (e.g., heart, arteries, veins, and capillaries), tendons, channels of the nervous system (e.g., the spine), and especially the head (known in Sanskrit as the *mahāmarman*, the "great vulnerable spot"). When a vulnerable spot is impaired or injured, the so-called wind humor in the area becomes irregular or agitated and moves throughout the body to regions where its excessive presence produces illness and potentially death (incidentally, this extreme result of an injured vulnerable spot is implied by its name, *marman*, which is derived from the Sanskrit verbal root √*mṛ*, "to die").[12]

The Sanskrit word for humor, *doṣa*, literally means "fault" or "taint." In Āyurveda there are three humors (*tridoṣa*): *vāta*, *pitta*, and *kapha* (or *śleṣman*), typically understood as wind, bile, and phlegm.[13] When snake venom enters a body, the wind humor (vāta-doṣa) becomes highly aggravated. There is a good deal of literature on the doṣas in Āyurveda and the roles they play in the determination of health and illness and, equally important, in the imagination of correspondences (or homologies) between individual human bodies and the cosmos. The doṣas are not merely conceptual items or indexical measures for speculation on diseases and their origins, though they do serve these functions. They are more than that in Āyurveda, insofar as they are understood to be fluid substances that circulate throughout the body.[14]

V.M.C.S. Namboodiri's commentary on oothu in the *Viṣavaidyasārasamuccaya* rationalizes the text's focus on the head and the wind humor with a reference to a discussion in the *Aṣṭāṅgahṛdayasaṃhitā*, a Sanskrit text from around the seventh century C.E., where the wind humor is catalogued into "five breaths" (*pañcaprāṇas*):

fore-breath (*prāṇa*)
up-breath (*udāna*)
middle-breath (*samāna*)
intra-breath (*vyāna*)
down-breath (*apāna*)

These five vital breaths originate in the head, from where they move downward through the throat, to the chest, and on to the lower regions of the body.[15] Properly calibrated breaths facilitate bodily movement, ensure mental acuity and proper breathing, and aid expulsion of waste from the body through spitting, sneezing, sweating, expectoration, urination, and excretion. When the five breaths are obstructed or irregular, physical debility, great pain, and sometimes death will follow.[16] V.M.C.S. Namboodiri's commentary emphasizes that the *Aṣṭāṅgahṛdayasaṃhitā* describes the experience of death as a separation of the five-part wind humor (especially the fore and up breaths) from the body.[17]

The procedure of oothu is a good example of the flexibility of ayurvedic theory in the clinical space of Malayali physicians.[18] It is designed specifically to pacify the key somatic component that venom attacks, the head, which is the primary seat of the wind humor, as well as the head's vulnerable spots.[19] The botanical medicaments the vaidya instructs a patient's attendants to chew and blow collectively have an antidotal quality (Skt., *viṣahara*). They include:

—ginger (Skt., *viśva* or *śuṇṭhi*)
—stinging nettle (Skt., *dusparśa*)
—black pepper (Skt., *marica*)
—Indian birthwort (Skt., *viṣavega* or *īśvarī*)

The "sharp" or "fiery" (Mal., *tigmaṃ* or *tigmaśaraṃ*; Skt., *tīkṣṇa*) properties of these plants are intended to protect and purify the critical spots of the fontanelle and ears. The administration of the medicine through breath is supposed to quickly vitiate the poison, while the controlled blowing therapy (Mal., *ūtucikitsā*) is meant to recalibrate the aggravated vital breaths of the patient.

V. Ritual Components

The connection between the theory contained in the texts and the practice of oothu underscores the intrinsic means-end nature of the procedure. The means of preparing the four plants and administering them with controlled breathing are intended to bring about certain ends: survival of the snakebite victim first and foremost; the mitigation of the venom in the patient's body secondarily; and thirdly, by ensuring survival, the patient gets a chance to cultivate a long and productive life. The means-end relationship of oothu is grounded on experience and attested theory. The success of the physician's direction of oothu rests on his or her "symbolic efficacy," in that the physician empowers the people gathered together with a sense of trust that she or he (i.e., the vaidya) can attend to this troubling situation with skillful execution and management (Lévi-Strauss 1963). The performance of blowing therapy at Mookkamangalam "gains its force," as J.Z. Smith said of ritual, precisely "where incongruency is perceived" (Smith 1980, 125). The incongruence of the human condition with the ideals of medical science (health and longevity, for example) contribute powerfully

to the "broken and ambivalent nature of our world," to echo Seligman, Well, Puett, and Simon. The attempt to cope with, if not to try to fix, that disagreement is at the center of the medical enterprise as much as it is a major function of ritual. Ritual practice, just as medical practice, "is a means of performing the way things ought to be in conscious tension to the way things are" (Smith 1980, 125). Ritual is therefore vital by the fact that in reality the ideal, the way things ought to be, cannot be realized perfectly or perpetually. Medical acts are ritualistic, then, when they work on the gap between ought and is, when they attempt to resolve "contradictions in which patients are enmeshed" (Finkler 1994, 188). To use Catherine Bell's terminology, these acts can be ritualized to varying degrees depending on the extent to which they work on the is-ought incongruity. Where do we see this mitigatory function of ritual at work in the medical context? To explain, I submit sociality, ordering, and cynosure as cardinal aspects of ritual activity, drawing on what we have seen in the foregoing description of oothu.

Sociality: Several people come together to perform oothu. In addition to a physician and a patient, the people who bring a snakebite victim to be treated make this procedure a truly social endeavor. People in the patient's entourage become far more than mere escorts. Whether they know it or not in advance (most do not), once they arrive at the gurukula clinic the patient's attendants play a significant role in the outcome of the healing process. They literally become ritual instruments of the physician. Apart from the snakebite victim and physician, ordinarily there are three other people involved (although oothu can be performed with just two others): one person to blow medicine into each ear of the patient and one to blow medicine onto the fontanelle of the patient's head. The attendants are usually members of the patient's immediate or extended family, but this relationship is not a strict requirement. They should not have consumed alcohol or eaten spicy food in the twenty-four hours prior to the treatment. The fiery qualities of alcohol and spicy foods increases the already sharp properties of the four herbs that are chewed and blown on the patient's head, which can produce more injury to the patient than healing.

In one of the two cases of blowing therapy discussed here the patient was female and in the other the patient was male. The female patient had two attendants: one male who blew into one ear, and one female who alternatingly blew onto the top of her head and into her other ear. The male patient had three male attendants, each one attending to a single location on his head. In both cases the patients arrived at Mookkamangalam not long after being bitten by a snake, and both survived. No one reported to know the type of snake that had bitten either patient. This is apparently common. If a snakebite victim displays any of the symptoms of envenomation, vaidyas at Mookkamangalam generally proceed with therapy swiftly, under the assumption that the case is potentially deadly. When I asked about gender alignment between patient and attendants, I was told this is not a decisive issue. The main priority is quick treatment, using readily available resources, rather than concerns of same- or cross-gender relationships in the administration of the drugs.

In Kerala, a visit to an ayurvedic physician—whether to traditional vaidyas like the ones at Mookkamangalam or licensed vaidyas working at an ayurvedic hospital or clinic—is often a social event. For the performance of oothu, a community is essential. Indeed, the male patient was semi-conscious when he was brought in. He therefore could not have travelled on his own. But in general, at Mookkamangalam patients rarely arrive unaccompanied to see the vaidyas no matter what illnesses they are experiencing, and a patient's companions play a crucial role in a vaidya's diagnosis. To gather information about why a patient has come to Mookkamangalam, vaidyas often do not speak directly to patients. They first speak with the people who brought them to be treated. Unlike during the practice of oothu, however, people who bring patients to traditional Malayali physicians generally are not actively enlisted to participate in the application of medicine. The general function of a patient's companion is to provide physical and emotional support, and to contextualize and communicate medical problems for patients who are unable to articulate these issues themselves. The reason for this is entirely pragmatic. For physicians there is great utility in having multiple perspectives about a patient's medical history for making diagnoses and rendering treatment.

When oothu is performed the physician-patient encounter is markedly different than the usual clinical encounters I have observed at Mookkamangalam and elsewhere in south India. During a routine visit, patients often stand or sit to the side of the people who brought them to the clinic; a vaidya might give them a cursory glance during the course of a conversation with their attendants. The background of each patient, including age and overall health history, family health history, day-to-day domestic living environment, and so on is routinely gathered. Then the attendants and the patient offer reasons they think the ailment has occurred and any prior attempts that have been made to treat the issue.[20] Medicine is not typically administered or even provided during a routine visit to Mookkamangalam. Instead the vaidyas or one of their student assistants tenders a kind of prescription, which lists herbs to purchase, includes instructions about how to cook the ingredients into a tonic, oil or paste

(Mal., *kaṣāyaṃ*, *thailaṃ*, or *cūrṇṇaṃ*), and outlines a daily, weekly and monthly dosage protocol.

In striking contrast, when oothu is required, due to the patient's distressed condition, medicines are administered forthwith on-site. The body of the patient quickly becomes the central focus of a social setting orchestrated by the vaidya. Plants are retrieved from the yard. Medicines are mixed. The physician instructs the patient's attendants to chew the plants (as presented in the *Jyōtsnika* and *Viṣavaidyasārasamuccaya*). They are then positioned around the patient's body, and directed to administer by blowing the prepared medicine. Actors, objects, and actions come together in recognition of an incongruence in the social nexus, disrupting, as Victor Turner described it, the human interrelatedness of communitas, which is in need of repair. Ritual activity in this instance is "a matter of giving recognition to an essential and generic human bond, without which there could be *no* society" (Turner 1969, 97—italics in the original), and trying to fix the broken communal link. At Mookkamangalam, the arrival of a snakebite victim points to a divergence between the *socially real* situation of a person possibly dying from snake venom and the *socially ideal* state of health expressed in medical theories of the body's humors, vulnerable spots, and vital breaths.[21] The snakebite victim's ailing status muddles the normal structure of social standings and hierarchies, which are, Turner noted, "rooted in the past and [extend] into the future through language, law, and custom"; rituals are therefore introduced in the absence or disruption of such structures (Turner 1969, 113). The urgency of the situation necessitates that socially corrective actions are taken, actions that have, in Turner's view, the "spontaneous, immediate, concrete nature of communitas, as opposed to the norm-governed, institutionalized, abstract nature of social structure." The sociality of ritual "is made evident or accessible, so to speak, only through its juxtaposition to, or hybridization with, aspects of social structure" that existed in the community of people with whom the patient is associated (Turner 1969, 127). In ritual activity people do not merely speak about things but they act out and practice something together, such as sets of social and familial relations that are not normally possible.[22]

Throughout the oothu procedure the vaidya acts as a kind of conductor, whose role is hands-off and largely heuristic. She or he attempts to classify the relationships that exist within the social scheme of the gurukula clinic—between a patient and the people in his or her immediate proximity—in order to promote healing (Durkheim and Mauss 1963, 81).[23] Healing has a socially re-integrative function in this context. The attendants' involvement is a sympathetic engagement with the patient's suffering, underscoring the importance of communal sharing and acceptance of the bodily suffering of a member of their group. In the course of blowing therapy, following Howard Brody's view of ritual, "a healing ritual becomes a bodily enactment of reconnection with the community" (Brody 2010, 162). The medical ritual in this way can "gradually transform the [patient's] existence," Finkler has argued, by "incorporating him or her, and sometimes the entire family, into ... new interpersonal networks" (Finkler 1994, 188–189). The transformation of the patient's life socially, the restoration of communitas, alters the patient's individual health.

Ordering: The ritual characteristic of ordering follows and overlaps naturally with the quality of sociality. Moore and Myerhoff made the case that social rituals by definition are organized events that bring together persons and cultural elements and have beginnings and ends. The order-element of ritual, they suggested, "is the dominant mode and is often quite exaggeratedly precise. Its order is often the very thing which sets it apart" (Moore and Myerhoff 1977, 7). Among the people involved in oothu, the patient brings to the group and embodies imbalance and disorder. The patient's eventual healing effectively remedies not only his or her individual condition, but this healing also restores the group of family and friends who have taken an active interest in the patient's wellbeing. Practically speaking, an oothu patient has been bitten by one of several types of snakes that populate Kerala—there are many, including the hooded mountain snake (Mal., *karināgaṃ*), the black and white ringed snake (*vaḷayappan*), and the ring snake (*vaḷapāmbu*), to name just a few. If the primary role of the physician is to direct and educate the group, her or his first objective is to reestablish physiological order in the patient. This order manifests through the interplay of the people in attendance at the gurukula, who move with the activity of a collective physiology and seek to create a correspondence between the ailing individual's body and the shared social milieu.

Traditionally, Malayali physicians recommend oothu to pacify the symptoms of snake venom during only the first three of the seven stages of venom maturation in the body. One of the Sanskrit medical classics, the *Suśrutasaṃhitā*, says that in the first three stages the effects of snake venom usually have not yet settled in the victim's abdomen, where the poison severely disrupts the body's humors (especially phlegm) and the digestive system. In the first stage, the venom infiltrates the blood, turning it black, after which, in the second stage, blackish skin appears, and then, in the third stage, the venom infiltrates the body's fatty tissues.[24] In actual practice, the vaidyas at Mookkamangalam perform oothu on patients with advanced symptoms and even on patients in semi-conscious states.

Continuously overseeing the assembly of people at the clinic, the vaidya keeps an especially close watch on the attendants' blowing to ensure consistent speed and uninterrupted frequency of breaths. Blowing continues until the symptoms noticeably diminish or are entirely eliminated. The procedure can last anywhere from 30 minutes to three hours. The two cases discussed here lasted approximately 40 minutes for the woman and almost an hour for the man. To control symptoms and bring physiological order to the patient, the actions of oothu neatly fit within the category of ritual actions Howard Brody calls "restorative rituals." That is, the vaidya attempts to move a sick person from a state of perceived disharmony and disorder within his or her social environment to a state of harmony and order (Brody 2010, 153).

Cynosure: Ritual acts point to and impose special meaning on various ordinary aspects of the world. They impart significance and command attention. As observers of certain practices, when we apply the adjective "ritual" to objects, acts, and actors, we are signaling significance. We are not attributing substance. In our attempt to construct definitions of ritual, we suggest these special actions carry weight because of what they represent—such as theories of the body, social construction, inversions of authority, and so on. On account of such significance, rituals warrant attention and special interest. We do not, for example, look at the gingerroot used in oothu as substantively different before and after it is masticated and blown on the snakebite patient. But when it is pulverized into a medicine with Indian birthwort, black pepper and stinging nettle, consumed by a group of people under the supervision of a vaidya, and repetitively blown on a patient, the herbs become part of a social process that commands a new attention to its various parts. The herbs collectively become a fiery brew that palliates the wind humor in the head; the people—physician and attendants—become guru and instruments (literal respirators!); the act of breathing becomes a process of moving medicated winds from within healthy bodies into an envenomed and unhealthy body. Oothu also commands a new attention to the environment. For the duration of the blowing therapy, there is a flow of affiliation between physician, patient, and attendants, streaming in vocal commands and herbal winds from a collection of bodies into one body in order to prevent the departure of the ailing body's five vital breaths, and hence preventing its death.

J.Z. Smith wrote that ritual is "a mode of paying attention" and "a process for marking interest" (Smith 1987, 103). For Smith, the characteristic of attention directly counters the claims of Protestant reformers in the 16th–18th centuries who asserted that rituals were empty and devoid of thoughtful intention, more like habits, which are marked by repeated performance and lack of forethought. Indeed it is common to find references to repetition in definitions of ritual. And though the textual accounts of oothu advise attendants to breathe medicine onto a patient up to 150 times, vaidyas at Mookkamangalam claim that the precise number of times one breathes these medicines is irrelevant. What is important is the symptoms of the venom abate; if this occurs after 60 or 80 breaths, then that is enough. Oothu is always patient-oriented. It is never done with 150 breaths as a strictly held yardstick, despite what the texts say. The number of breaths has little value, for too few breaths just as too many can be equally deleterious to a patient. A vaidya's primary job is to observe the practice of the attendants and the recovery or loss of health in the patient, accordingly moving the procedure onward or calling it quits.[25]

For Smith the characteristic of marking interest also highlights the essential role of place in ritual. If for Moore and Myerhoff order sets ritual activity apart from other types of activity, place, Smith famously said, "directs attention" (Smith 1987: 103). Ritual environments are specially marked-off areas in which everything is positioned for definite reasons, everyone acts according to certain formulas, and all things (and some people) therein require undivided attention. If place directs attention, then things (and some people) within the confines of the marked-off places—ritual objects and actors—become special by virtue of simply being present. That which makes them special and more significant than if they were elsewhere is the attention directed at them, attention that is demanded on account of their emplacement in the marked-off space. That which makes ritual objects and actors special is for Smith and others (all of whom are indebted to Durkheim) often called the sacred. But for Smith, "the ritual is not an expression of or a response to 'the Sacred'; rather, something or someone is made sacred by ritual" (Smith 1987, 105). The sacredness of the objects and people in ritual activity derives from their emplacement. There is no inherent difference between these people and objects when they are in a ritual environment (a temple, mosque, or church) as opposed to when they are outside of it. When they are inside of it, however, the attention they receive makes them special and extraordinary.

VI. Conclusions

Do the people and the objects involved in oothu become special and extraordinary by virtue of following the

logic of the vaidya's orchestration and their emplacement at the gurukula clinic? Yes and no. Their participation in the procedure makes them extraordinary in the sense that they become ritualized agents, who, because of their performance demand special attention. The collective actions of the group disrupt normal experience, and under the careful guidance of a vaidya each person enacts what Schechner has called "hyper-experience." This experience is not abstract, but "is made of definite sensuous items to do, smell, hear, see, and touch." Oothu illustrates well Schechner's shrewd observation that, "more than any other kind of art or entertainment, ritual is synaesthesis" (Schechner 1985, 194).[26]

That said, I would not follow Smith further, and suggest that oothu, of necessity, makes these people and objects sacred. Instead of getting caught in the secular-sacred dichotomy when the question of ritual activity is invoked, and thus forever holding the work of physicians and priests at odds (recall Grimes's quote above), what is needed is a stricter activity-based, or practice-oriented, lens for identifying and analyzing ritual. As an observer of medical practices, to pose the question—Is there ritual in medicine?—is not to enquire about the presence of or reliance on transcendent entities in a person's or group's performance. That might be there for the doctor just as well as it might be for the priest. Even still, both professionals can be said to perform ritual, given certain characteristics like the ones I have sketched in the procedure of oothu. So, yes, the short answer to the question is that there can be rituals in medicine. We might extrapolate from the analysis of the qualities of sociality, ordering, and cynosure in oothu to systems of medicine other than Āyurveda (or more precisely, Malayali poison treatment, *viṣacikitsā*), such as Unani, Siddha, Traditional Chinese medicine, and even biomedicine, as well as to other cultural domains like education, politics, and religion. When these three flexible characteristics are present, we can identify ritual activity that is not exclusively under one cultural province, but illuminates human activity across cultural domains. Flexibility of the components that make up our definition is critical. There will be different kinds of rituals and also different degrees of ritualization. With an analytic framework in place, ritual is potentially identifiable in all areas and institutions of human culture.

We can still be more precise with our documentation of ritual, however. Within the conceptual categories of sociality, ordering, and cynosure, there are types of ritual action we can further distinguish and analyze. In particular a distinction of action may be drawn between ritual rehearsal and ritual performance. I deliberately draw these two types of ritual activity from performance studies. They are meant to evoke the theatre in the sense that, for the ethnographer, the act of theorizing ritual in any context is necessarily an act of observing and commentating on the staging of a spectacle (in the fundamental sense of a specially prepared and arranged display).[27]

Ritual rehearsal is a practice marked by the process of returning to something again and again, not of one's accord, but at the prompt of directives heard or read. Moore and Myerhoff called this ritual acting: "a basic quality of ritual being that it is not an essentially spontaneous activity, but rather most, if not all of it is self-consciously 'acted' like a part in a play ... [and it] usually involves doing something, not only saying or thinking something" (Moore and Myerhoff 1977, 7). A ritual rehearsal, then, is an action performed by an actor who does not have, think he has, or care to have the requisite knowledge or capacity to achieve the goal of his practice without guidance. Success depends on someone or something (like a text or a screenplay) external to the actor. An example of a ritual rehearsal could be prayer, since it depends on an appeal to an entity beyond the control of the actor (God, Allah, Vishnu, Ahura Mazda, and the like) for a certain result. Caroline Humphrey and James Laidlaw wrote about this in terms of "guided" action and "ritual commitment" on the part of the actor (Humphrey and Laidlaw 1994, 5). Similarly, the involvement of most medical patients in their treatment, in the preparation and regular taking of prescribed drugs, fits within the category of ritual rehearsal. Patients certainly play a part in their recovery. But their capacity to be cured is contingent upon the expertise and work of others well beyond their control, including the physicians who make diagnoses and prescribe medicines and their doses, as well as the manufacturers of the drugs that are ingested.

A ritual performance is marked by the actor's awareness of her competence to accomplish what she sets out to do. The ritual performer knows she has the requisite knowledge and capability to accomplish her desired goals. A ritual performance is done by someone who is skilled, trained to carry out effectively a certain action or set of actions, who possesses the capabilities and productivity to execute or operate successfully when measured against a certain preconceived standard. Aspects of oothu fit neatly within this category. Oothu, in fact, exhibits elements of both ritual performances and ritual rehearsals. A vaidya's recommendation and direction of blowing medicinal herbs is a ritual *performance*: it is predicated on tested theories, observed data regarding human physiology, and years of clinical experience. The vaidya's role as director of a group is evocative of directorial staging. Cru-

cial to oothu's success are the vaidya's capacity to generate in his actors "at least an attentive state of mind, and often an even greater commitment of some kind ... through manipulations of symbols and sensory stimuli ... and through highly structured, rule-bounded activities, both of which produce concentration so extreme that there is a loss of self-consciousness, and a feeling of 'flow'" (Moore and Myerhoff 1977, 7–8). The work of an oothu patient's attendants, in comparison, is an example of ritual *rehearsal*: following Catherine Bell's description of ritual agents, the attendants of the patient during blowing therapy "do not see how they have created the environment that is impressing itself on them but assume, simply in how things are done, that forces beyond the immediate situation are shaping the environment and its activities in fundamental ways" (Bell 1997, 82). These forces are the healing properties of the drugs, the expertise of the vaidya, and the support derived from the group gathered together.

Another way to talk about what is expressed and produced in oothu is to use the concept of ritualization. This term accentuates the ongoing process inherent to ritual and the movement of a person's or a collective's performance to communicate something that remains beyond the individual actors. Ritualization underscores the fact that ritual is dynamic and generative, not static. Mary and Max Gluckman used ritualization to refer to the acting out of social relationships in order to express and alter a given situation, usually a conflict, for the purpose of achieving a material end (Gluckman and Gluckman 1977, 233; also Gluckman 1962, 24). On this view, oothu can be seen as a medical ritualization that involves a group of people whose interactions express and attempt to alter the conflict of illness. Ritualization thus encompasses the ritual qualities of sociality and ordering. Bell's analyses further adds the quality of cynosure, or demanding attention by being different. "Intrinsic to ritualization," she wrote, "are strategies for differentiating itself—to various degrees and in various ways—from other ways of acting within any particular culture. At a basic level, ritualization is the production of this differentiation" (Bell 1992, 90 and Bell 1997, 81). According to a practice-oriented analysis, oothu highlights the distinction between the envenomed physiology of a patient and an ideal physiology outlined in the Sanskrit and Malayalam medical literature, which the attending cohort of the patient aims to bring into existence by becoming instruments of the vaidya. By having a patient's family or friends both draw attention to, and attempt to counteract, the course of venom in a patient's body, oothu compels social reciprocity and the ordering of incongruence.

Oothu as ritualization is not a series of acts that renders sacred the whole therapeutic process. Yet the process is made different through strategic means (Bell 1992, 90–93, 204ff), as we have seen in the ritual aspects of sociality and ordering. The decisive punctuation in the process of ritualization, however, is the condition that sets apart, begs attention, and gives special significance to the ritual process. This is the ritual aspect of cynosure. Interrelated though the three aspects of ritual are, framing them within the category of ritualization helpfully conveys the understanding that rituals entail progressions. The social and ordering aspects help to generate the cynosural attention that ritual eventually demands.

In applying a practice-oriented approach to the study of ritual, we avoid reading into oothu merely what we want to know by imposing conceptions and beliefs on to the ritual actors' frames of reference (Bell 1997, 265). By looking to the "methods, traditions and strategies of 'ritualization'" we do not discuss ritual (and ritualization) in universal terms or along the lines of binaries like sacred-profane and religious-secular, or even religion-medicine, which often obscure analyses of acts that are performed in certain situations (Bell 1997, 82). Instead, a case-by-case analysis of practice—the vaidya's orchestration of textual history, plantlife, a patient's body, and human instruments—speaks to the ways in which certain experts and a community come together to attend to situations of incongruity (emergencies, illnesses, snakebites). The idiom of ritual theory is tremendously helpful in explaining the events of this south Indian medical practice. The language used need not have recourse, or carry an unstated presumption to belong, to any one domain of human culture like religion. The characteristics of sociality, ordering, and cynosure may apply to the medical context as well as the religious context. We may use these analytic categories in other domains, too, and ask if ritual activity exists in the classrooms of higher education in North America or the in the halls of our political institutions. The foregoing scrutiny of oothu as a ritual activity suggests that the ritualist and the medical doctor need not see their work as incommensurate. The aporia with which we began this discussion can be resolved, in no small measure by carefully identifying what the term ritual is meant to do when it is deployed and by purging the language used to describe ritual activity of any enduring assumptions that it is properly qualified by linguistic markers of one segment of society vis-à-vis another.

Notes

1. I am grateful to the two anonymous reviewers who commented on an earlier draft of this manuscript. I am also grateful to Bo Sax and the participants in his research seminar at the South Asia Institute of Heidelberg University, where in May 2013 I presented portions of this article. The response to my presentation in Heidelberg was invigorating, and the questions and comments of everyone in the seminar helped me a great deal in bringing clarity and economy to the final product. Many thanks go to Serena Bindi for commenting on an early draft of this article. Finally, I thank the National Endowment for the Humanities, the European Institutes for Advanced Study, and the Institut d'études avancées de Paris for generously supporting portions of the fieldwork and writing of this article.

2. Incidentally, medical pluralism has been a reality in India for at least two millennia, according to the classical Sanskrit *saṃhitās* of Caraka, Suśruta, and Vāgbhaṭa, as well as later works, where we find references to non-Indian medical systems and peoples.

3. To preserve the anonymity of the physicians and their patients, I am using a fictionalized place names.

4. The transcription—*oothu*—is the most colloquial rendering in Kerala today of this Malayalam term in the Roman alphabet. I use the unitalicized rendering—oothu—throughout this article. The more orthographically technical transcription is *ūtu* (from the verb, *ūtuka*, "to blow").

5. I am grateful to Dr. Madhu K.P. and Tsutomu Yamashita, director of the Program for Archiving and Documenting Ayurvedic Medicine (PADAM), for providing me with additional video and photographic documentation of the two cases discussed here.

6. This list could go on and on and on, drawing on classic examples from Frazer's *Golden Bough* to Marx's "Theses on Feuerbach" to Freud's *Future of an Illusion* and more recent ones, such as Talal Asad's important oeuvre, especially his famous rejoinder to Geertz's definition (1993; see also 2009) and the protracted discussion that Daniel Dubuisson's book, *The Western Construction of Religion* (2003), instigated among theorists of religion like Steven Engler, Russell McCutcheon, and Aaron Hughes (see Engler and Miller 2006). But my aim here is not to enter the debate about what constitutes religion per se. It is about when and why the analytic category ritual was absorbed within the study of religion.

7. The work by Eliade in question here is *The Sacred and the Profane: The Nature of Religion* (1957). But Eliade made use of the notions of sacred and profane in more than just this work, including *Patterns in Comparative Religion* (1958), *The Quest: History and Meaning in Religion* (1969), and *The Myth of the Eternal Return* (1971).

8. When a means-end relationship is intrinsic to activity, the means plainly bring about the end consistent with progressions that are valid according to scientific causation.

9. "J'appelle technique un acte *traditionnel efficace* (et vous voyez qu'en ceci il n'est pas différent de l'acte magique, religieux, symbolique). Il faut qu'il soit *traditionnel et efficace.*"

10. None of this is to say that social actors themselves never speak about ritual. Although in this study I am interested to analyze the scholar's intentions and conceptions when she or he deploys the category ritual, we should not lose sight of the fact that social actors have their own emic categories of ritual that might or might not accord with the etic types imposed by scholars. The word in non-academic usage in the United States, for example, often carries with it associations with religion and psychology. People who claim to perform ritual tasks (whether they are identified as such by scholars or not) might be aware that some of their actions are different than others and even have a different kind of (or an anticipated) efficacy. From the researcher's point of view, the frame of reference through which the category of ritual is applied is important to acknowledge and explain.

11. *Jyōtsnika* 4.20: ūtū nūṟṟampateṉṉī ṯṯu śrōtrayōrmmūrdhani kramāl / ennāloḻiññpōmāśu mūnnudhātuvilē viṣaṃ.

Viṣavaidyasārasamuccaya (Uttarabhāga) 122: viśvadusparśamarica viṣavegān samāṃśakān / vaktre dhṛtvā daṣṭakasya karṇayormūrdhni cāsakṛt (27) phūtkāraṃ yugapat kuryussapañcāśataṃ śanaiḥ / tvagādi dhātutrayagaṃ viṣaṃ hanyādidaṃ param (28).

12. *Suśrutasaṃhitā* Śārīrasthāna 6.24–43.

13. By way of comparison, in ancient and medieval European medicine, there were thought to be four humors in the human body: blood, phlegm, choler (or yellow bile), and black choler (or melancholy). The relative proportions and locations of these substances were thought to determine a person's temperament, mental faculties, and overall bodily health.

14. Francis Zimmermann has explained the linguistic development of the term doṣa in Āyurveda from its original meaning as "fault" or "taint" (1989, 144–145). The doṣas are unlike other bodily elements, for at once they are bodily fluids as well as a body's primary pathogenic arbiters. Consequently the semantic range of the term "doṣa" in Āyurveda is layered. There is a clear application of a specialized (or medical) meaning of doṣa based on the term's primary evocative meaning of fault or taint. This layering belongs to the Sanskrit rhetorical rule (*tantrayukti*) of *hetvārtha*, "the thing [implied] by its cause" (or simply "implication"); this is the metaphorical process by which the common use of the term picks up a technical or specialized use. Zimmermann has explained this process along the lines of catachresis (1989, 146). The result is that the ayurvedic doṣa has three layers of meaning: the primary meaning of fault or taint, the technical meaning (and most common in the Sanskrit medical literature) of "humor," and the metaphorical meaning of pathogenic somatic entity (cf., peccant, à la Thomas Sydenham's "peccant humour").

15. The *pañcaprāṇas* are seen elsewhere in Sanskrit literature, going back to the Brāhmaṇas and Upaniṣads (ca. 700–400 BCE).

16. *Aṣṭāṅgahṛdayasaṃhitā* Sūtrasthāna 12.4-5a: prāṇādibhedātpañcātmā vāyuḥ prāṇo 'tra mūrdhagaḥ / uraḥ kaṇṭhacaro buddhihṛdayendriyacittadhṛk // ṣṭhīvanakṣavathūdgāraniḥśvāsānnapraveśakṛt.

17. *Aṣṭāṅgahṛdayasaṃhitā* Nidānasthāna 16.56b-57a: viśeṣājjīvitaṃ prāṇa udāno balamucyate // syāttayoḥ pīḍanāddhānirāyuṣaśca balasya ca.

18. The term "Malayali" refers to a Malayalam-speaking person, and denotes someone who is from or inhabits the southwestern Indian state of Kerala.

19. *Carakasaṃhitā* Cikitsāsthāna 23; *Jyōtsnika* Cikitsākramādhikāram 53.

20. Many patients at Mookkamangalam have gone through various other types of treatment for their disorders before coming to the vaidyas at this gurukula. These treatments often include biomedical therapies and drug regimens as well as attempts at treatment in other ayurvedic contexts, such as a private or government ayurvedic hospitals.

21. On the function of ritual to acknowledge the separation be-

tween the real and the ideal state of a social situation, see J.Z. Smith (1987, 41).

22. On this, see the study of Houseman and Severi, *Naven or the Other Self: A Relational Approach to Ritual Action* (1998). This work is a good example of theorizing ritual, and in particular the characteristics that distinguish ritual action, through a sustained ethnographic study of Naven ritual and family relations (in this case among the Iatmul of the Sepik River region in Papau New Guinea).

23. For Durkheim and Mauss, conceptual classifications of material things are reproductions of the same classifications among humans. They moved away from Frazer's postulation that conceptual categories precede and shape social groupings that people develop, and they argued that people "classified things because they were divided by clans" (1963, 82).

24. For example, see *Suśrutasaṃhitā* Kalpasthāna 5.

25. On the privileging of the patient's condition over procedural rigidity, the Namboodiri vaidyas at Mookkamangalam cite *Aṣṭāṅgahṛdayasaṃhitā* Sūtrasthāna 12.55, 70–73.

26. Schechner further noted that "there is a also a corresponding set of skills known to the ritualists for operating the performances" (Schechner 1985, 194). The specialists in the Kerala gurukula are the vaidyas. But interestingly, the attendant too becomes something of a ritualist in the course of oothu (although he or she requires the direction of the vaidya to undergo this transformation).

27. My ideas about these distinctions have been informed by personal conversations with Erik W. Davis, as well as his insightful analysis of the Cambodian *paṃsukūla* (Davis 2012).

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