# The Dawn of the Physician: A Buddhist Approach to the History of Medicine

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**Abstract:** Today, various Buddhist traditions in East and Southeast Asia are renowned for also conveying specific medical practices, from Tibetan Buddhist medicine to Japan's Buddhist healers, and from the medico-Buddhist traditions of Thailand to those of China. The Buddhist world has always been intertwined with medicine; however, if we aim to trace the origins of this idea and the reasons for this association, for instance in the Pāli Canon, we find a remarkably clear and profound perspective on the roles of the Buddhist ascetic and the physician as two distinct figures addressing a common problem. Consequently, their methodological and theoretical engagements can be considered to intersect in a fascinating manner. This contribution specifically aims to analyse these differences and intersections, laying the groundwork for an archaeology of Buddhist medical thought beginning with the Pāli Canon.

**Keywords:** Buddhism and medicine, medical conception in Buddhism, early Buddhism and illness, archaeology of medical thought, semantic history of medicine

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## 1. Introduction

> 'You need to take medicine when there's disease. With no disease no medicine is needed'.
> (*roge hi... sati bhesajjena karaṇīyaṃ hoti, roge asati na bhesajjena karaṇīyaṃ hoti*, MN 75)[1]

The present article aims to reflect on the role and emergence of the figure of the physician in Buddhism through readings of the Pāli Canon, commented upon in comparison with what we know about medical knowledge in the South Asian world. In particular, this article will focus on the conception of illness, understood from a technical perspective as a dysfunction of the body, and will particularly highlight how the Pāli Buddhist Canon already contains elements of a primordial medical reflection in the form of the three humours (potential cause of disease), which indeed make their first appearance in the texts of the Pāli Canon and later in Āyurvedic literature.

It should also be noted that this comparison with the Pāli Canon does not aim to elevate the suttas of the Pāli Canon as the ultimate ancient testimonies. In fact, various studies have shown that while some sections of the Pāli Canon are indeed ancient, others are significantly more recent.[2] Therefore, since not all the suttas we will analyse belong to the sections or layers considered the most archaic, this paper does not intend to provide a general notion of antiquity, even though, as several authors we will mention have demonstrated, certain medical ideas indeed make their first appearance in the Pāli Canon.[3] This does not mean that the Buddhists invented them, but rather that they probably inherited them from an earlier substratum

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[1] Unless otherwise indicated, all translations are my own.

[2] See the review of studies in Divino, 'An Anthropological Outline of the Sutta Nipāta'. According to some authors, one of the most ancient Buddhist texts is the Gāndhārī Dharmapada (see Schopen, 'Two Problems in the History of Indian Buddhism', 25). Nonetheless, since this text does not present medical contents, we will not address it here.

[3] On this matter see Divino, 'Humours and their Legacy', 14–24.

shared with the Āyurvedic tradition, though they are, in a sense, the first attesters of these ideas, at least based on the knowledge currently available to us. Therefore, considering these intentions, we will focus on the Pāli Canon primarily because it falls within my area of expertise and because its attestations are particularly interesting for the purposes of our discussion.

Despite the Pāli Canon metaphorically portraying the Buddha as an ideal physician (*sallakatto anuttaro*), it must be noted that the figure of Siddhatta Gotama and that of a general physician are clearly distinguished in these texts. Nevertheless, this does not preclude the metaphorical validity in associating the Buddha with a therapist (if one wishes to use a more appropriate term). However, the Buddha appears to focus on a specific form of distress, *dukkha*, whereas the physician is well described in the Canon as a technical figure dealing with *roga*s, understood as more targeted dysfunctions such as organ diseases and infections.

More precisely, the roles of the physician and the Buddhist ascetic appear to emanate from a shared archetype of a healer, of which Buddhists inherited a portion. In conjunction with their 'therapeutic' ethos, they also attest to the emergence of a technical therapist specialised in the treatment of ailments and dysfunctions.

Numerous anthropological hypotheses have been put forward regarding the emergence of the physician figure as a convergence of various 'religious' roles, often encompassed under the common designation of 'medicine-man'.[4] These roles reflect the therapeutic functionalities carried out by figures such as ascetics, priests, and shamans, all loosely connected by the fact of dealing with the supernatural.[5] A similar figure is well attested also in the Vedic culture: a healer (*bhiṣáj*) that Zysk explicitly compared to 'the medicine-man of the North and South American Indians among other people', as he was described to perform a special ritual involving dancing, chanting and possibly also medicinal herbs 'to restore a patient, attacked by a

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[4] Eliade, *Shamanism*; Hultkrantz, 'The Shaman and the Medicine-Man'; Bhasin, 'Medical Anthropology'.

[5] Zysk, *Religious Medicine*, 3.

disease-demon or suffering an injury'.[6] For now, I will not delve further into the potential issues of the anthropological theory,[7] which has certainly undergone various amendments. Our focus here is on the figure of the physician in Buddhist thought and the medical idea that such thought carries.

In the panorama of global medical traditions, the significance of Buddhist contributions is now well acknowledged.[8] Various schools of Buddhism have developed their own medical traditions within the framework of their doctrines, to the extent that today, we can speak of Tibetan Buddhist medicine or Chinese Buddhist medicine.[9] Thailand and other parts of Southeast Asia are also important when we speak of medical traditions conveyed through Buddhist monasteries.[10] Even Japan's distinct medical tradition is a reflection of the significant role played by Buddhism.[11]

While this aspect is inherently intriguing as it indicates a fundamental inclination of Buddhist thought towards healing practices, what has been less explored is the origin of this attitude. Nowadays, it is still believed that the Buddhist medical tradition in India was sparked by interactions with Āyurvedic practices.[12] This hypothesis has come under increased scrutiny, leading to a growing awareness that Buddhism developed its own original medical knowledge, perhaps drawing from prior traditions transmitted among itinerant ascetics,[13] which encompassed knowledge of herbal therapy[14] and

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6 Zysk, *Medicine in the Veda*, 8.

7 Shimoji, Eguchi, Ishizuka et al., 'Mediation'; Apud and Romaní, 'Medical Anthropology and Symbolic Cure'; Finkler, 'Sacred Healing'.

8 Salguero, *A Global History*; *idem*, 'Buddhist Medicine'; *idem*, 'Toward a Global History'.

9 Salguero, 'Buddhism & Medicine'; *idem*, 'The Buddhist Medicine King'.

10 Salguero, *Traditional Thai Medicine*.

11 Triplett, *Buddhism and Medicine in Japan*.

12 Mukherjee, Harwansh, Bahadur et al., 'Development of Ayurveda'.

13 Zysk, *Religious Medicine*; *idem*, *Asceticism and Healing*; *idem*, 'Studies in Traditional Indian Medicine'.

14 Salguero, 'Toward a Global History', 43.

anatomy. Evidence suggests that the medical framework delineated by Buddhism not only diverges from the type of medicine that could have developed from Vedic traditions[15] but also serves as the factual precursor to concepts found in Āyurveda, with their earliest attestation found in the Pāli Canon: 'The very earliest reference in Indian literature to a form of medicine that is unmistakably forerunner of Āyurveda is found in the teachings of the Buddha'.[16] We can assume that Buddhism and Āyurveda were derived from a common root due to their similarities; however, there is a clear distinction between the 'empirical-rational' tendency of Buddhism and the more ritual-based—'magical-religious'—healing practices found in the Vedas.[17]

Early Buddhism exhibited a marked empiricist tendency concerning medicine,[18] comparable in complexity to Hippocratic medicine.[19] Aspects meriting consideration include the attention to anatomy,[20] the notion of fundamental constitutive elements of human health (three humours: *vāta*, *pitta*, and *semhasa* and the four great elements) and the understanding that their interaction, as well as their alteration (a quantitative variation resulting in the qualitative change of the humours), forms the basis for interpreting symptomatology: 'The Buddha's list of disease-causes emanates from a milieu in which a body of systematic technical medical knowledge existed'.[21]

Moreover, and notably, Buddhism developed a semantic conception around the idea of disease, seamlessly integrated into its epistemological framework and in dialogue with its philosophy. In this regard, Buddhism also theorises the figure of the 'physician' as a health professional distinct from a healer.[22] However, in the Pāli Canon, this

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15 Wujastyk, 'The Science of Medicine', 401.

16 Wujastyk, 'The Path to Liberation', 31.

17 Zysk, *Asceticism and Healing*, 21.

18 Salguero, *A Global History*, 19.

19 Divino, 'Humours and their Legacy', 8–13.

20 Divino, 'Elements of the Buddhist Medical System', 31–43.

21 Wujastyk, 'The Path to Liberation', 32.

22 The physician as a professional in the realm of illness is a figure who, anthropologically speaking, is difficult to distinguish from other specialists in the

phase remains incipient. An analysis of these texts alone allows us to discern the emergence of the physician figure within the Buddhist epistemological framework, the progressive structuring of a concept of disease specifically understood as a technical term for health-related dysfunctions and the development of a bona fide 'medical system'.

This text analyses the rationale behind the hypothesis of archaic Buddhism as a proponent of a certain notion of medicine. We can even go so far as to assert that medical theory was the constituent element of the intellectual movement that elevated medicine to its foundational principle, subsequently expanding it to the transcendental realm and rendering the Buddha as more than a mere 'health technician' but rather the proponent of a *medicīna ūniversālis*.

This investigation will be structured into two main sections. Initially, an analysis of the Pāli Canon will be undertaken to elucidate elements pertaining to the conceptualisation of health and disease. Within this initial segment, an exploration of the elements facilitating the proposition of a novel medical paradigm within the Buddhist context will ensue, encompassing an examination of the various conceptual innovations that arose therein. Subsequently, the inquiry will shift focus to briefly address another question: what were the contextual circumstances—socio-cultural, historical, and religious—fostering the emergence of such medical ideologies?

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spiritual or religious domains, such as ritual technicians who also assumed the role of healers, ascetics, or shamans possessing healing abilities or transmitting therapeutic knowledge within their religious traditions. When the figure of the physician-healer began to specialise autonomously across various cultures, it was often a slow process that nonetheless retained certain elements of the previous tradition through the role of the physician. What I aim to assert in this work is that a similar process, in the case of the Indian medical traditions, was precisely documented by Buddhist literature. The figure of the physician as a technical specialist in the treatment of illness in India was first attested within the Buddhist framework, a philosophy that, in turn, utilises medicine and the figure of the physician as a metaphor for its doctrine, constructing a dialogue between diverse yet interconnected practices, perhaps contributing in part to the semantic definition of concepts related to illness.

## 2. Physician or Ascetic

The depiction of the physician (*tikicchaka*, *bhisakka*, and many other names) and the ascetic (*samaṇa*) within Early Buddhist thought appears to exhibit a certain degree of fluidity; both were considered 'therapists' (of illness or suffering), experts in the medical arts or 'healers' of mundane sufferings. The two figures share many common aspects, but they were treated as separate entities, like in the case of Jīvaka, personal physician of the Buddha but not a real *samaṇa*. The Pāli Canon furnishes not only the earliest documentation of a structured epistemological framework within medical discourse—ranging from the theory of the three humours (*dosas*) to comprehensive anatomical knowledge—but also marks the emergence of the idea of the physician as a distinct professional entity specialising in the treatment of illness (*roga*). Like a physician, the ascetic possesses medical knowledge and situates their practices within a therapeutic paradigm, whose primary concern remains the alleviation of *dukkha* and a holistic resolution of profound malaise.

While the usual prototypical figure of the healing ascetic embodies both a therapist of illnesses and a healer of afflictions—indeed, one could argue that there was no perceived difference between these two roles in ancient times—the Buddhist tradition separates it into two distinct typologies: illness as dysfunction (*roga*/*ruja*), whether mental or organic,[23] and existential malaise, crisis, anguish and affliction as intrinsic conditions of the human, conveyed by a term (*dukkha*) usually translated as 'suffering', even though it carries a much broader and more complicated meaning.[24]

While an individual may be in good health or afflicted with illness,

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[23] AN 4.157 clearly states that *roga* as a dysfunction or a mundane illness can be both physical and cognitive, as it is related to the thought-sphere: *dveme*, *bhikkhave*, *rogā... kāyiko ca rogo cetasiko ca rogo*. Additionally, these conditions are widespread to the point where it is difficult to find someone who is completely free of them: *te, bhikkhave, sattā sudullabhā lokasmiṃ ye cetasikena rogena muhuttampi ārogyaṃ paṭijānanti, aññatra khīṇāsavehi*.

[24] Vetter, 'Explainations of Dukkha'; Peacock, 'Suffering in Mind'.

existential ailment operates on a different plane; it persists irrespective of health status because it is inherent to the human condition. Consequently, it necessitates a different form of 'treatment', one that entails transcending the human condition itself and worldly concerns. In this regard, the branching of these two typologies indeed leads to a more specific determination of the two concepts and hence the two roles, but it does not imply a stark dualism or radical separation between the two figures and conditions.

Reasonably, there exists a vertical hierarchy rather than a horizontal binary, as it is explicitly reiterated that the Buddha, in many respects, resembles a physician, with his practice similar—but not identical—to medical healing. Thus, a parallel is drawn between the 'healing' performed by the physician of illness and that carried out by Buddhist teachings on the human existential condition that requires healing (see Table 1). However, the latter therapy is superior, leading to the overcoming of even the conditions—of interest to the physician—allowing illnesses to arise.[25]

The Pāli Canon presents numerous terms indicating illness as 'dysfunction' (such as *roga*, *byādhi*, *ābādha*, and *vyasana*), specifically as a result of humoral imbalance (which is not the case with *dukkha*, despite the other similarities between this condition and illness). Among these 'technical' terms, the most prominent is undoubtedly *roga*, while the others often serve as complements to it, sometimes appearing as synonyms and other times indicating more

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[25] An example of the discourse on emetics found in AN 10.109 is evocative in this context. Here, the Buddha acknowledges the existence of physicians (*tikicchakā*), thereby implying that they are not necessarily synonymous with *samaṇa*s, and he further acknowledges that these figures primarily use emetics (*vamana*) to treat disorders of bile, phlegm, and wind (*pittasamuṭṭhānānampi ābādhānaṃ paṭighātāya, semhasamuṭṭhānānampi ābādhānaṃ paṭighātāya*). He also recognises that such medicines exist, but they are not infallible. Thus, he introduces an infallible emetic, and using the emetic metaphor, he enumerates all the things this correct medicine would expel, for instance, with the formula: 'For one who has right view, wrong view is vomited up' (*sammādiṭṭhikassa, micchādiṭṭhi vantā hoti*).

**TABLE 1 The *roga*/*dukkha* axis as a possible explanaion of the difference between the role of the physician and that of the ascetic in Early Buddhist thought.**

| **Possible common origin** | **Medicine-man, magician, healer, proto-therapist...** | |
|---|---|---|
| Specialist figure | Physician (*tikicchaka*) | Ascetic (*samaṇa*) |
| Problem addressed | ***roga*** | ***dukkha*** |
| Kind of threat | Dysfunction: physical or cognitive (*kāyiko ca rogo cetasiko ca rogo*) | Existential suffering, inherent to human condition, unease, unhappiness |
| Origin of the threat | Mainly a humoral imbalance or colligation, mundane factors, misfortunes | Crisis, generalised human condition, ignorance (*avijjā*) |
| Healing | Customised therapy, prescription of medicaments, emetics, other kinds of medicines | Liberation (*vimutti*), contemplative practice (*bhāvanā*), noble eightfold path, world transcendence (*lokassa atthaṅgama*) |

specific forms of illness. The subject of these factors is the *gilāna*, the patient—another technical term.

Similarly, the 'physician', indicated by terms distinct from *samaṇa* or *bhikkhu* and notably not assimilable to them, emerges as a specialist in 'illness' as opposed to the ascetic, who specialises in *dukkha* and seeks recovery from what is an existential condition. This distinction does not imply mutual exclusivity in roles, but the canon nonetheless presents a certain firmness in reiterating that the distinction is vertical, not horizontal: the Buddha is not a physician like Jīvaka, possibly not even possessing his 'technical' knowledge—pharmacological, anatomical, and physiological—at a level sufficient to address humoral imbalance or 'illness' (*roga*). However, the Buddha emerges as the *sallakatto anuttaro* insofar as recovery from dukkha implies liberation from the condition that gives rise to *roga*s too. The reverse, however, is not possible. As long as one remains in the human and worldly condition, one may be subject to the conditions that lead to the onset of illness (conditions carefully enumerated and described

in the suttas). In such cases, the physician may intervene and prescribe medications and therapies. If they prove effective, the illness dissipates. This situation necessitates targeted treatment or therapy whenever illness arises or necessitates behaviour aimed at avoiding its causes. Now that we have elucidated the differences between *roga* and *dukkha* according to the Pāli Canon, we may proceed to the analysis of passages that demonstrate this theory.

## 3. What Does a Physician Do?

Regarding the *dukkha*/*roga* axis, whose distinction has previously been discussed in a separate study,[26] we can also observe a difference between the 'therapeutic' mission of the Buddha—often interpreted through the formulation of the Four Noble Truths in a model resembling aetiology (*idaṃ dukkhaṃ*), diagnosis (*samudaya*), prognosis (*nirodha*), and prescription (*magga*)—and the more technically targeted role of the physician (*bhisakka* or *tikicchaka*). While these two figures seem to overlap in many respects, numerous instances exist where the physician's role is distinct from the Buddha's.[27]

For a clear examination of the role of the physician and their modes of treatment, we will analyse certain occurrences within the Pāli Canon that mention the physician's role. Within these passages, it becomes evident that medical therapy, according to Buddhists, is perceived as distinct from freedom from *dukkha*, though there are instances where this latter state is conceivable as a form of 'therapy', signifying liberation from all possible diseases. However, the figure of the physician is distinctly delineated and to some extent revered, at least within many of these passages.

Prior to engaging in an analysis that dissects the disparities be-

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[26] Divino, 'Elements of the Buddhist Medical System'.

[27] Here, I am not referring solely to the figure of the Buddha but also to the figure of the Buddha as one who follows the Dhamma and thus the path of the *samaṇa*, whether as an *arahant*, a *paccekabuddha*, or through any accepted path that leads to bodhi.

tween the two figures and thereby elucidates the specific characteristics that define a physician, it is prudent to first examine the areas of convergence between such a role and a Buddha.

As previously mentioned, on numerous occasions, the figure of the Buddha is likened to that of a physician, not only because the Noble Eightfold Path resembles a therapeutic model but also because it is imperative to emphasise that the Buddha is the preeminent healer: 'O mendicants, I am a brahmin, devoted to charity, generous, experiencing his last life, the ultimate physician and surgeon' (*ahamasmi, bhikkhave, brāhmaṇo yācayogo sadā payatapāṇi antimadehadharo anuttaro bhisakko sallakatto*). In passages found in Snp 3.7 and MN 92, the Buddha presents himself as 'ultimate surgeon' (*sallakatto anuttaro*) and as 'surgeon and great hero' (*sallakatto mahāvīro*), 'crusher of Death's army' (*mārasenappamaddana*).

We turn our attention to this initial statement reported in Itivuttaka 100 (*Brāhmaṇadhammayāgasutta*, Iti 100). The first qualities that the Buddha proclaims about himself are naturally those to which we are accustomed: *antimadehadhara*, he who has reached the final of reincarnations (i.e., who bears the last of his bodies; *antima-deha-dhara*), generosity, and charity. However, the Buddha ultimately compares himself to the highest (*anuttara*)—that is, to the best or unsurpassed—of physicians (*bhisakka*) and surgeons (*sallakatta*). We do not know if this distinction was made because this expertise needed to be separately articulated or because it represented a different profession altogether.

Another term used to indicate the physician is *tikicchaka*, meaning 'healer' or 'doctor'. In AN 10.108, the *tikicchaka* is described as one who 'prescribes purgatives to eradicate diseases arising from disorders of bile, phlegm, and wind' (*virecanaṃ denti pittasamuṭṭhānānampi ābādhānaṃ paṭighātāya, semhasamuṭṭhānānampi ābādhānaṃ paṭighātāya, vātasamuṭṭhānānampi ābādhānaṃ paṭighātāya*). Here, we witness a technical definition of the physician—the Indian theory of humours appears articulated in a structured manner for the first time in the Pāli Canon.[28] This does not prove that Buddhists

[28] Scharfe, 'The Doctrine of the Three Humors'.

were the first to develop this idea, as it is equally probable that it was inherited from the traditions of itinerant asceticism that transmitted knowledge and 'medical' theories pertaining to the art of healing ailments.

Certainly, Buddhism presents this theory in an organic, structured form, and it is imperative to note that the systematic organisation of a knowledge system—of an epistemology—always denotes a will to manage a problem. In this case, the problems of illness and suffering are closely related. The Buddha continues, 'Such purgatives exist, I do not deny' (*atthetaṃ ... virecanaṃ; 'netaṃ natthī'ti vadāmi*), thus acknowledging the role of the medical specialist as legitimate. However, this technical role has imperfections: 'Such types of purgatives are sometimes effective, sometimes ineffective' (*tañca kho etaṃ, bhikkhave, virecanaṃ sampajjatipi vipajjatipi*).[29] Here, the necessity for greater management overlaps; it is through the assertion of the incompleteness of the medical arts that the Buddha proposes his 'therapeutic' art, as a complement to the management of a problem that medical technique does not solve perfectly.

The figure of the Buddha is not entirely detached from that of the physician. However, while the latter appears as a branch of the ascetic healer who develops a certain technical competence to manage the crises derived from illness,[30] the Buddha emerges as another parallel branch, proposing his own healing arts. Indeed, that of the Buddha is described as a purgative, albeit a 'noble purgative' (*ariyaṃ virecanaṃ*), which additionally boasts the advantage of being infallible

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[29] The same formula is repeated in suttas like AN 10.109.

[30] The relationship between experiences of crisis and illness is a subject that has been explored by Ernesto de Martino's anthropological works. He reflects on the origin of religious thought, beginning with the experiences of the magical as a mechanism developed to confront crises, with illness and death being among the primary causes of such crises. Magic was thus present at the dawn of those figures that arose to protect presence, evolving into the medicine man on the one hand and the priest on the other. See de Martino, *The World of Magic*, and *idem*, *The End of the World*.

(*yaṃ virecanaṃ sampajjatiyeva no vipajjati*). The cure, more precisely the 'complete liberation' (*parimutti*, *parimuccati*), advocated by this purgative is a remedy for the greatest human afflictions (such as in AN 10.108).

If we consider medicine within Buddhism as evidence of a specialised discipline, then the technical concept of illness and the figure of the physician will correspondingly entail an interest in those subject to illness and the care of the physician. These individuals, whom we may designate as 'patients', are the *gilānā*. We can trace this term back to the root *glā* ('to fade, wither, be exhausted'), yet its usage in Pāli clearly denotes 'being sick' or 'unwell'. The discourse in AN 3.22 directly concerns them: 'There exist in the world three types of patients' (*tayome... gilānā santo saṃvijjamānā lokasmiṃ*). The pervasive interest of Buddhism in lists and classifications should not be underestimated. It extends considerably beyond the medical realm, but Zysk already hypothesised that this mode of reasoning concealed their fundamentally empirical approach.[31]

The three types of patients addressed in AN 3.22 pertain to their response to different medicaments (*bhesajja*): 'There are some patients who, despite acquiring the beneficial medicines and foods, regardless of benefiting from the proper carer, do not recover from their illness' (*idha, bhikkhave, ekacco gilāno labhanto vā sappāyāni bhojanāni alabhanto vā sappāyāni bhojanāni, labhanto vā sappāyāni bhesajjāni alabhanto vā sappāyāni bhesajjāni, labhanto vā patirūpaṃ upaṭṭhākaṃ alabhanto vā patirūpaṃ upaṭṭhākaṃ neva vuṭṭhāti tamhā ābādhā*). In this case, the technical term employed to indicate illness, *ābādha*, literally refers to a condition of 'oppression', and it is usually translated as 'affliction, illness, disease'.

The second type of *gilānā* concerns those who recover from their affliction regardless of whether they receive the proper medicine and nourishment or benefit from the proper carer. Even today, certain medical conditions remain mysterious, with patients recovering spontaneously, while at other times, therapy fails despite being considered the appropriate treatment for an illness. The clarity with

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[31] Zysk, *Religious Medicine*; *idem*, *Asceticism and Healing*.

which Buddhism already identified this problem is commendable, yet a physician's interest lies in identifying the correct therapy and focusing on those who benefit from it:

> Therefore, O mendicants, there are some patients who can recover from affliction only if they acquire the beneficial medicines and foods and benefit from the proper carer, while they do not recover if they do not obtain these things. Well then, O mendicants, such a patient who obtains healthy food, not obtaining unhealthy food, who obtains the correct medicine and not the incorrect one, who benefits from the proper carer and not the improper carer, he recovers from the illness. Monks, it is for the benefit of this patient that it is allowed this type of food for the patient, this type of medicine for the patient, these types of carers for the patient. But also, O mendicants, it is for the benefit of this patient that even other types of patients are assisted.
> *idha pana, bhikkhave, ekacco gilāno labhantova sappāyāni bhojanāni no alabhanto, labhantova sappāyāni bhesajjāni no alabhanto, labhantova patirūpaṃ upaṭṭhākaṃ no alabhanto vuṭṭhāti tamhā ābādhā. tatra, bhikkhave, yvāyaṃ gilāno labhantova sappāyāni bhojanāni no alabhanto, labhantova sappāyāni bhesajjāni no alabhanto, labhantova patirūpaṃ upaṭṭhākaṃ no alabhanto vuṭṭhāti tamhā ābādhā, imaṃ kho, bhikkhave, gilānaṃ paṭicca gilānabhattaṃ anuññātaṃ gilānabhesajjaṃ anuññātaṃ gilānupaṭṭhāko anuññāto. imañca pana, bhikkhave, gilānaṃ paṭicca aññepi gilānā upaṭṭhātabbā*.

The sutta concludes by drawing a parallel between proper therapies and medicines and the path to Buddhahood, where some may enter the path to Buddhahood by virtue of their meritorious qualities. However, this condition is like that of medicine, as not all individuals possess such qualities, just as some do not enter Buddhahood even if they see a realised one and hear Buddhist teachings. Instead, there are those who, upon hearing the teaching of someone who is realised (*tathāgatappaveditaṃ*), become a subject (here called *puggala*) who can certainly enter Buddhahood (*okkamati niyāmaṃ kusalesu dhammesu*...), and it is for the benefit of these individuals

that the Buddhist Dhamma is spread.[32] Thus, there are three types of subjects just as there are three types of patients in the world (*tayome gilānūpamā puggalā santo saṃvijjamānā lokasmiṃ*).

Although a parallel is thus drawn between Buddhist teachings and medicine, it also seems clear that in this sutta, the two disciplines differ in some ways. This addresses the question 'what does a physician do?', or rather, 'what distinguishes them from the Buddhist ascetic tout court?'. The answer is provided in AN 10.108:

> O mendicants, doctors prescribe purgatives [*virecanaṃ*] to eradicate afflictions generated by bile [*pittasamuṭṭhāna*], those generated by phlegm [*semhasamuṭṭhāna*], and those generated by wind [*vātasamuṭṭhāna*]. Such purgatives exist, I do not say otherwise. However, O mendicants, sometimes such purgatives work, sometimes they fail [*virecanaṃ sampajjatipi vipajjatipi*]. And I, O mendicants, teach about the noble purgative [*ariyaṃ virecanaṃ desessāmi*], this is the purgative that (always) works and does not fail [*yaṃ virecanaṃ sampajjatiyeva no vipajjati*].
> *tikicchakā, bhikkhave, vamanaṃ denti pittasamuṭṭhānānampi ābādhānaṃ paṭighātāya, semhasamuṭṭhānānampi ābādhānaṃ paṭighātāya, vātasamuṭṭhānānampi ābādhānaṃ paṭighātāya. atthetaṃ, bhikkhave, vamanaṃ; 'netaṃ natthī'ti vadāmi. hañca kho, bhikkhave, ariyaṃ vamanaṃ desessāmi, yaṃ vamanaṃ sampajjatiyeva no vipajjati*.

Naturally, the sense of this teaching is, on the one hand, to reiterate the fallibility of medicines, although their general therapeutic value is recognised ('such medicines exist, I do not say otherwise'), and on the other hand, to reinforce Buddhist teaching. We recall once again the hierarchical verticality of the Buddhist

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[32] *tatra, bhikkhave, yvāyaṃ puggalo labhantova tathāgataṃ dassanāya no alabhanto, labhantova tathāgatappaveditaṃ dhammavinayaṃ savanāya no alabhanto okkamati niyāmaṃ kusalesu dhammesu sammattaṃ, imaṃ kho, bhikkhave, puggalaṃ paṭicca dhammadesanā anuññātā. imañca pana, bhikkhave, puggalaṃ paṭicca aññesampi dhammo desetabbo*.

medical conception—medicines exist. Sometimes they work, and sometimes they do not. Buddhist teaching, on the other hand, is indeed like a medicine, but it never fails. Above all, it guarantees sentient beings (*sattā*) a definitive liberation (*parimuccanti*) from all worldly torments: birth, ageing, death, sorrow, lamentation, pain, sadness, and distress (*jātidhammā jātiyā, jarādhammā, maraṇadhammā, sokaparidevadukkhadomanassupāyāsadhammā*, *sokaparidevadukkhadomanassupāyāsehi*). Another medical metaphor is as follows: Buddhism intends this passage, which involves the right view, right thoughts, right speech, right actions, right livelihood, right effort, right mindfulness, right concentration, and right wisdom, as a process of purification, a transition from *akusalā dhammā* to *kusalā dhammā*.

## 4. Medical Technicalities

Regardless of their hypothetical development from a common archetype probably antecedent to Buddhism itself, the physician and the ascetic are two distinct figures in Buddhist conception. Although the two figures employ a similar methodology, they address two distinct problems. This holds true even insofar as they present multiple possible nomenclatures, which are to be understood simply as indicating nuances, phases and implicit roles within their practice and thus within their semantic sphere: *samaṇa*, *bhikkhu*, *pabbajita*, *arahant*, and so forth in one case and *tikicchaka*, *bhisakka*, *vejja*, and *sallakatta* in the other.

Buddhism is known for employing a particularly precise and accurate lexicon, a general attention to words that should not be underestimated. It could be said that no term is used carelessly if it is in the Pāli Canon, including the poetic layers, presumably the oldest of the same.[33] Therefore, this section reflects on the differences in the Buddhist medical lexicon concerning the semantic sphere that developed around the core of roga, aware that a similar discourse could

[33] Shulman, 'Early Buddhist Imagination'.

have developed for *dukkha*.

Existential therapy is indeed at the heart of Buddhist discourse, where *dukkha* is a state difficult to define but described through pathological metaphors. The overcoming of dukkha is a process that is itself of a 'therapeutic' nature. In other words, the Four Noble Truths are comparable to a diagnostic process that starts with identifying an illness (the first truth: *sabbaṃ dukkhaṃ*) before tracing its aetiology (the second truth on the origin of suffering: *ayaṃ dukkha-samudayo*), elaborating a diagnosis (the third truth on the cessation of suffering: *dukkha-nirodha*), and finally prescribing therapy: the *magga* ('path') to be followed.

Likewise, even illness (*roga* and its variants) has a well-determinable genesis through specific and recognisable causes. The plane is vertical: *dukkha* is an existential condition that affects all beings in the world (*loka*). Its genesis, starting from ignorance (*avijjā*) in the system of dependent origination, which resides in equally mundane elements (i.e., the relativity of perceptual constituents that combine in the five aggregates; *pañcakkhandha*), reveals that overcoming this problem implies the deconstruction of the world itself. Hence, the 'therapy', liberation from *dukkha*, coincides with the end of the world, or perhaps its transcendence,[34] which is also the cessation of *avijjā* or the cessation of the *pañcakkhandha*.

The discourse concerning illness is instead fully embedded in mundanity, but it is no less important to be aware of it. Despite the impermanence of the constituents of the physical body, Buddhists do not simply dismiss the problem doctrinally by announcing its emptiness. Instead, the meditator is invited to phenomenologically learn it through meditations centred on the decaying corpse (*bhikkhu seyyathāpi passeyya sarīraṃ*, MN 10), the repulsiveness of one's own body (*kāyānupassanāpaṭikūlamanasikārapabba*, DN 22), the meditation on the image of the skeleton (*aṭṭhikasaññā*, SN 46.57), the meditation on the putrefaction (Snp 2.2),[35] or even on exercises of

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[34] Divino, 'In This World or the Next'; Divino and Di Lenardo, 'The World and the Desert'.

[35] Snp 2.2 is more broadly discourse on the nature of food and putrefaction

the dismemberment of the body (*bhikkhu imameva kāyaṃ uddhaṃ pādatalā adho kesamatthakā tacapariyantaṃ pūraṃ nānappakārassa asucino paccavekkhati*, DN 22), listing organs with a meticulousness that cannot but make us suspicious about the anatomical knowledge of Buddhists.[36]

These meditative exercises are also comparable to the initiatory dismemberment of a shaman's body found in other cultures,[37] but in Buddhism, the exercise of listing organs is interesting as an attestation of attention to anatomy. The body must be 'analysed' and 'dismembered' through these mental exercises to see what the body really is, since usually, we do not see it for what it is (*chaviyā kāyo paṭicchanno, yathābhūtaṃ na dissati,* Snp 1.11). The body is 'held together' by bones and sinews (*aṭṭhinahārusaṃyutto*) and covered with 'flesh and skin' (*tacamaṃsāvalepano*). This exercise, similar to what we found in DN 22 where the body is dissected and the organs are listed as one would with the grain in a bag that can be opened for the scrutiny of its contents (*ubhatomukhā putoli*...), shows its several anatomical components, such as 'guts, belly, liver, bladder, heart, lungs, kidney, and spleen' (*antapūro udarapūro, yakanapeḷassa vatthino; hadayassa papphāsassa, vakkassa pihakassa ca*..., Snp 1.11)—all things usually hidden from our sight.[38] The list goes on to include blood, synovial fluid, bile, and grease (*lohitassa lasikāya*, *pittassa ca vasāya ca*). As we can see, sometimes included among the

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and the importance of eating 'good food', which can be seen as another form of medical attention, since in many other suttas, the consumption of the proper nourishment is associated with good health, whereas bad food is linked with the emergence of disease. Furthermore, the consumption of food derived from killed animals is always connected with bad consequences, and it is thus called food of putrefaction: 'Killing living beings, mutilate, murder abduct them... this is putrefaction and meat not to be eaten indeed' (*pāṇātipāto vadhachedabandhanaṃ... esāmagandho na hi maṃsabhojanaṃ*).

[36] Divino, 'Elements of the Buddhist Medical System', 31–43.

[37] Walsh, 'The Making of a Shaman'; Jokic, 'The Wrath of the Forgotten'.

[38] Other suttas containing anatomical views or analyses of body composition can be found in AN 3.36 4.157, 5.78, 9.34, 10.60 and 10.108.

fluids are some humours (*pitta* in this case).[39]

Similarly, the body is indeed impermanent, but it is not deserving of inattention from the ascetic (see DN 28). The good Buddhist cares for the sanity, strength, and exertion of his own body (*āraddhavīriyena thāmavatā purisathāmena purisavīriyena purisaparakkamena purisadhorayhena, anuppattaṃ taṃ bhagavatā*). The other distinctive characteristic of ancient Buddhism is indeed how its asceticism radically diverges from the 'self-mortification practices' (*attakilamathānuyogamanuyutto*) that are accused of being derogatory towards the body and of being proponents of the extreme of nihilism. The good Buddhist rejects the mortification of the body and takes care of themselves as long as they dwell in mundanity. In other words, mortifying practices are seen as useless (*anatthasaṃhitaṃ*) and ignoble (*anariyaṃ*), causing unnecessary suffering to the meditator who derives no real benefit from these exercises other than provoking further suffering. Finally, the most well-known aspect of those engaged in Buddhist medicine is the belief that bodily health is governed by the balance of three elements: the three humours. This system is well known in Āyurveda but has its oldest attestation in the Pāli Canon and is effectively a memory of an empirical spirit that attempts to trace even mundane ailments to

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[39] Similar lists of body parts 'dissected' by the Buddhist gaze also appear in SN 35.127, 51.20 and AN 10.60. In the last example, these lists are accompanied by an enumeration of possible diseases, most of which are marked by the suffix *-rogo* (e.g., *cakkhurogo*, *sotarogo*, *ghānarogo*, *jivhārogo*, *kāyarogo*, *sīsarogo*, *kaṇṇarogo*, *mukharogo*, *dantarogo*, *oṭṭharogo* and *kucchirogo*). Other diseases are defined by the term *ābādhā*, which, in this context, clearly denotes a 'disturbance', 'imbalance' or 'disorder', as it accompanies the eightfold classification previously discussed (*pittasamuṭṭhānā ābādhā, semhasamuṭṭhānā ābādhā, vātasamuṭṭhānā ābādhā, and sannipātikā ābādhā*). There are additional disorders without any determinative, such as tuberculosis (*kāso*), asthma (*sāso*), fever (*ḍāho*), dysentery (*pakkhandikā*), cholera (*visūcikā*), leprosy (*kuṭṭhaṃ*) and epilepsy (*apamāro*). The determinative *-rogo* thus clearly serves to indicate a malfunction or dysfunction of an organ or process, as in the case of *cakkhurogo* ('disease of the eye' or 'eye disease') or *dantarogo* (toothache).

well-identifiable causes in the world itself.[40]

If we delve into the technicalities specific to the medical lexicon, we can observe the prevalence of certain key terms. It is important to emphasise once again that Buddhism does not present itself as the inventor of medicine per se, as the figure of the physician is clearly distinct from that of the ascetic. Furthermore, there is the well-known circumstance of Jīvaka, the personal physician of the Buddha,[41]

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[40] It is imperative to underscore that the present discourse endeavours to conduct a textual analysis and construct an archaeology of the concept of medicine within ancient Buddhism. However, while adopting Zysk's perspective on empirical-rational medicine, I do not intend to ascribe to these terms any connotation implying an equivalence between modern allopathic biomedicine prevalent in the Western world and the medical ideas of archaic Buddhism. Empiricism as a philosophical current originating in Greece delineates specific inclinations that I do not aim to indiscriminately apply to Buddhist medicine. Rather, my intention is to highlight how Buddhist medical thought evolved from particular investigative interests concerning the body or illnesses that bear resemblance to empiricism at certain junctures. Thus, we may designate them as such, employing the more common and generic usage of the term without thereby detracting from Buddhism its distinctiveness, as discernible from the analysis of these texts. Similarly, the contention to assert the superiority of empirical-rational medicine within Buddhism, based on a semblance to allopathic biomedicine, is a fallacious argument from the outset, not only because equivalence is unattainable but also because it disregards the fundamental cultural relativity of medical systems, which are not absolute abstractions of real and objective knowledge but rather products of epistemological frameworks evolving within specific historical and cultural contexts. We cannot divest ourselves of this semantic history of ideas, not even with the purported absolute objectivity claimed by modern science, which nonetheless remains a cultural product of our era and, therefore, should be cautious in claiming absoluteness and incontrovertibility. Hence, ours is not an exercise in the assimilation or hierarchical arrangement of these medical practices but rather one of contextualisation within their cultural and philosophical reality, that of ancient Buddhism and the India of the time. This allows us to account for more nuanced reflections of medical anthropology and the cultural history of ideas.

[41] Zysk, 'Studies in Traditional Indian Medicine'.

whose affiliation with the saṅgha or adherence to Buddhist Dhamma are unclear, though initially this may not have been so.[42] Nevertheless, Buddhism bears witness to a certain notion of 'empirical' medicine that contributes to its development, constructed from certain 'medical' concepts or clearly medical ways of reasoning found in the Canon and also utilised by the Buddha.

The first 'technical' concept is of course that of *roga*, meaning 'disease'.[43] As previously mentioned (see also Table 1), there are numerous terms indicating illness or disease, but they all essentially refer to the semantic sphere of *roga*, which is the preferred technical term used by the Buddha when discussing disease in general, in contrast to *dukkha* as an existential condition.[44]

The first scholar to propose a comparative study of the terms *roga* and *dukkha* was Hashimoto,[45] who, in his analysis, also included other similar terms such as *byādhi*. For Hashimoto, the use of the term *byādhi*, and its variant *vyādhi*, denotes a technical term indicating the cause of *dukkha*. His textual analysis clearly elucidates this causal relationship from *byādhi* to *dukkha*, although I do not

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[42] Crosby, *Esoteric Theravada*, 146.

[43] The term *roga* is evidently a technical term well-suited for medical employment. Most likely, this term can be traced back to the verbal root *rujati*, meaning 'to break', 'to shatter', 'to dash to pieces', 'to destroy', and 'to injure', and thus to an Indo-European root from which terms such as the Latin *lūgeō* ('to mourn'), Lithuanian *lūžti* ('to fracture'), and the Old English *tōlūcan* ('to dislocate' and 'to destroy') derive. Its usage is roughly analogous even outside the Buddhist context. More challenging to interpret is the root of *dukkha*, which a once-popular interpretation saw as connected to *duḥstha*. This interpretation was probably favoured due to the root *sthā-* ('to stand'), also present in the term *sukha* (< *sustha*). Given the frequent opposition Buddhists draw between *sukha* and *dukkha*, a binomial interpretation between *su-* ('good') and *dus-* ('bad') has been considered. However, it is more likely that these terms referred to having a 'good or bad axle-hole'. Thus, by extension, the term *dukkha* metaphorically indicates a state of precariousness, of constant risk of collapse.

[44] Divino, 'Elements of the Buddhist Medical System', 30.

[45] Hashimoto, 'Roga to Dukkha'.

fully agree with some of his conclusions regarding *roga* (病気). Overall, however, we can understand *byādhi* as a general term encompassing other types of diseases (以外の病気) not technically defined by more specific terms. Concerning the term *roga*, Hashimoto explained it as something encompassing both cognitive and physiological dysfunctions. The juxtaposition Hashimoto noted between the state of absence of *roga* (*aroga* or *ārogya*) and nirvāṇa is also significant.

Regarding the difference between *roga* and *dukkha* (苦), it must first be noted that the former term is connected to the concept of *anicca* (無常), but Hashimoto essentially treated *roga* and *dukkha* as interdependent. In other words, the former is the origin of the latter.[46] Thus, we are presented with this dual analysis: Everything revolves around *dukkha*, in the sense that it is either caused by (*byādhi*) or originated from (*roga*). The *byādhi–dukkha* relationship is akin to that between subject (主語) and predicate (述語).

When the problem of defining what constitutes illness arises, we enter into the realm of a classical issue in medical anthropology. This often entails a separate discussion, as illness is definable only as the absence of health, which in turn can only be defined as the absence of illness.[47] Inevitably, the health/illness dichotomy falls within the realm of absolute arbitrariness, as culture defines the boundaries that delineate a healthy individual, unless one resorts to subjective discretion. In such an event, the condition of 'feeling unwell' is as variable as the number of people in the world, with each individual having their own way of feeling ill or not.

This is a problem of which Buddhists themselves seem to be well aware. Ultimately, illness does not exist, yet at the same time, the texts seem to recognise the need to conventionally employ this term to convey concepts functional to the teaching that although objective, static, and incontrovertible illness is hardly discernible, discomfort certainly exists. This is ultimately a problem of a normative nature, where binary concepts such as pure and impure, normal and abnor-

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[46] Hashimoto, 'Roga to Dukkha', 307.

[47] Bhasin, 'Medical Anthropology'.

mal, fall within the tools that a system of power can utilise to shape subjectivities. Buddhism vehemently opposes such processes of subjectivation, and if it rejects identity as a static value (*anattā*), it must also reject the orthodox logical system that employs the principle of *dhārmika*/*adhārmika* to shape those very subjectivities.

The manner in which it does so, at least in the medical realm, is by deconstructing cognitive habits or by extending the semantic scope of concepts that would otherwise be binary. We have already seen how Buddhism utilises meditative exercises on disgust, the impure, and the image of the corpse or skeleton, repugnant elements that normative orthodoxy would tend to classify as *adhārmika* and upon which the Buddha seems to insist. Perhaps this is also to teach the meditator that such concepts are not 'by their nature' impure. Nevertheless, it is the cognitive habituation dictated by normative force that creates this opposition. However, Buddhism does not reject the concept of purity altogether, and it employs it to convey its Dhamma, describing multiple times pure and impure conducts. What it truly seems to vehemently reject is the application of the impure state based on caste or social hierarchy, which is the extension of a 'medical' instrument to the social dimension.

In Snp 4.4, a discourse is constructed precisely on the relationship between purity and illness, reflecting on the one who is 'ultimately pure and free from illness' (*suddhaṃ paramaṃ arogaṃ*). The ultimate purity aspired to by the ascetic cannot be attained by remaining attached to concepts (*saññasatto*) that are ultimately conventions and thus values based on dualistic oppositions. Ultimate purity is, paradoxically, that which surpasses the pure/impure dichotomy. This seems to be reiterated in the following section (Snp 4.5). This section states that those who are attached to the idea of an 'absolute' truth (*paramanti diṭṭhīsu*) and, by virtue of their beliefs about what is good or bad or worse or better (*hīno*, *visesī*), slide into conflict. This quarrelsome attitude is ultimately criticised.

Another widely used term in Buddhism is *lakkhana* (Skt. *lakṣaṇa*), meaning 'characteristic'. A philosophy concerned with the meticulous investigation of reality naturally employs this term extensively. However, as noted by Friedlander, *lakṣaṇa* originally served as

a medical technicality, precisely indicating 'symptom'.[48] This choice was not incidental. Buddhism considers human suffering akin to an ailment—there are specific causes and conditions leading to distress (*dukkha*). Therefore, distress can be treated with 'therapy'. Similarly, Friedlander posited a correlation between the medical theory of the three humours and that of the 'three poisons' in Buddhism.[49]

A term effectively analogous to this is *nidāna*. In the Āyurvedic context, *nidāna* is utilised with a sense akin to αἰτία (*aîtía*) in Greek medicine, while in Buddhism, *nidāna* denotes a cause closely linked to the issue of actions, particularly those leading to rebirth. Hence, the discourse revolves around the three poisons (*lobhajaṃ dosajañceva, mohajañcāpaviddasu*..., AN 3.34). Greed, hate and delusion are delineated as the three causes of deeds (*tīṇimāni... nidānāni kammānaṃ samudayāya*) also in AN 6.39, whereas in SN 12.60, nidāna is implied to elucidate the interrelationship of factors from craving to rebirth, old age and suffering.[50] Once again, we observe the utilisation of a medical logic, that of 'poisons', to convey a pedagogical message with a therapeutic framework.

## 5. Humours

The foundation of Āyurvedic medicine lies in the theory of the three

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[48] Friedlander, 'The Body and the World in Buddhism', 55.

[49] Ibid., 58.

[50] Greed is also considered one of the three ancestral illnesses. According to Snp 2.7, 'There were once just three kinds of illness: greed, starvation and old age, but due to the slaughter of cows, they grew to even ninety-eight' (*tayo rogā pure āsuṃ, icchā anasanaṃ jarā; pasūnañca samārambhā, aṭṭhānavutimāgamuṃ*). This passage can also be read as another attestation of early Buddhist vegetarianism, since it correlates the multiplication of illnesses to the killing of animals, which testifies to both the rejection of the Vedic institution of sacrifice and the idea that the consumption of meat is somehow impure and must be avoided for the sake of good health. It is epitomised also as 'unwholesome violence' (*adhammo daṇḍānaṃ*) of an ancient (*purāṇo*) custom.

humours (*tridoṣa*), which bears striking resemblance to concepts found in Hippocratic medicine. In Āyurveda, these humours are termed *vāta* (wind), *pitta* (bile), and *kapha* (phlegm),[51] and they are understood to be present within the body, contributing to its health. An imbalance in these humours inevitably affects the other humours and one's psychophysical well-being. It is plausible, as we have observed, that this systematised understanding may have deeper historical roots. The Pāli Canon references various episodes related to medicine or physiology, and in a well-known instance mentioned in SN 36.21, three humours (*dosa*) are cited: *vāta*, *pitta*, and *semha*. This attestation 'is perhaps the earliest formulation of the *dosa*-theory'.[52] Their description evidently corresponds to the same humours in Āyurvedic theory. The term *semha*, denoting phlegm, might be linked to the Sanskrit *śleṣman*, an Āyurvedic equivalent of *kapha*.[53] These humours are mentioned in the Pāli Canon, which incorporates them into the classification of the seven types of somatic tissues (*dhātu*): 'chyle, blood, flesh, fat, bone, marrow and semen'.[54]

According to Friedlander, in the medical conception underlying ancient Buddhism,

> Illness was seen as being as basically the result of blockages in the flow of the humors and the elements around the body, and its causes as relating to humors not being in their proper seats in the body, environmental factors, such as climate and diet, and mental factors or divine causes.[55]

Furthermore, every human body is composed of fundamental units of matter (*paramānu*) that can manifest in four essential configurations, or four elements (*mahābhūta*), that correlate with the

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[51] See Divino, 'Humours and their Legacy' for more information on this topic.

[52] Zysk, 'Doṣas by the Numbers', 2.

[53] Friedlander, 'The Body and the World in Buddhism', 51.

[54] Ibid., 52.

[55] Ibid., 51.

four stages (*mūlabhūta*) found in the philosophical formulations of numerous Indian traditions, including Sāṃkhya with its theory of three qualities (*guṇa*): goodness (*sattva*), expansive energy (*rajas*), and inertia (*tamas*). This close relationship between the analysis of physics and physiology shared by the oldest philosophies of India helps to reveal the centrality of medicine in Buddhist thought.

Equally fundamental is the complete absence of a psychic dimension in ancient Buddhism. From a Western perspective, this absence is reduced to either materialism or a form of primitivism. In reality, Buddhism does not conceive of the psyche, nor the body, as mere matter, since it does not reduce psychic processes to physiological processes or vice versa. Instead, Buddhism relies on an entirely different and highly complex conception: 'In early Buddhism the understandings of consciousness and the seats of consciousness were not the same as in modern thought in relation to where consciousness resides in the body. In particular, the idea that the brain is the place where all mental activity takes place is not found at all'.[56] This standpoint leads to a distinction with Āyurveda, where the *citta* finds its precise abode in the heart, alongside emotions, whereas in Buddhism, *citta* corresponds to cognition, which is equally linked to the noetic and emotive process but is also a core of temporary subjectivity.[57]

As previously stated, the Pāli Canon is most likely the earliest attestation of a theory of the three humours in India. This theory reappears in Āyurveda; however, it is noteworthy that it is never mentioned in the 'Bhesajjakkhandhaka', the chapter dedicated to medical prescriptions within the collection of monastic rules in the Theravāda canon. The latter text is curious in many respects and appears, for example, to be quite distinct from other medical or purity considerations found in the suttas, such as those related to meat consumption, where there is significant divergence.

Nevertheless, by focusing solely on the suttas, we can outline a general framework of the Buddhist theory of humours, or at least

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[56] Friedlander, 'The Body and the World in Buddhism', 53.

[57] Johansson, 'Citta, Mano, Vinnana—A Psychosemantic Investigation'.

the one attested by Buddhists. In this regard, a recent work by Zysk is the most up-to-date and comprehensive, and thus, we will also refer to this publication.[58] The most important points we learn from this archaic theory are the following:

1. The humours are three elements that actively contribute to the health of the human body. While they seem to be associated with specific functions, it is explicitly stated that these three must be in balance with each other.
2. An imbalance of the humours leads to the onset of disease. Similarly, disease can arise from their displacement. Each humour has a designated area of the body to which it belongs. Moving from that area is akin to an imbalance.
3. The humours can increase or decrease simultaneously, a particular condition termed 'colligation' (*sannipātika*), which also appears in Āyurveda but was first formulated by Buddhists.

Although the theory of the three humours is often thought to be the only 'medical' innovation to appear in the Buddhist tradition, it should be noted that, in fact, other causes are associated with the three humours, even in the Pāli Canon. Specifically, this theory relies heavily on numerical associations. Zysk believes there is a connection between the number three and, for instance, the same numerical categorisation found in other Indian philosophies that subsequently engaged with medical theory. Notably, the three *guṇa*s of Sāṃkhya philosophy are also organised into a triad and constitute the ontological reasoning of Sāṃkhya.[59] As fundamental constituents of matter, the humours are naturally also present in the body, and their connection to medical theory is well known insofar as each *guṇa* is associated with its prevalence in certain foods, which, when consumed, can positively or negatively affect health.[60] A comparison with Āyurvedic

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[58] Zysk, 'Doṣas by the Numbers'.

[59] Ibid., 7.

[60] This tendency to associate food with moods is also traceable in the Pāli

literature confirms that the humours sustain the body and that the body is dependent on the humours for its existence.[61]

Zysk thus sees a link between this tripartition and that of the humours. Additionally, other significant numbers include four (which also appears in the organisation of the Four Noble Truths) and eight (the Noble Eightfold Path), both of which are also present in archaic Buddhist medical theory. Among the causes of disease, the number eight is present among the causes, in the form of a doubled quadruple system. An initial quadripartition is given by the imbalance of a single humour (one cause each, thus three causes) plus a fourth cause given by colligation:

> The use of the expression 'humoral colligation' (Pali *sannipātika*) in the Buddha's list is particularly telling. This is not just an ordinary item of vocabulary. It is a keyword, a technical term from ayurvedic humoral theory. In classical ayurvedic theory, as received by us from medical encyclopaedias composed several centuries after the Buddha, 'humoral colligation' is a category of disturbance in which all three humours are either increased or decreased simultaneously.[62]

This first quadripartite set is supplemented by four additional causes that are of non-humoral origin and arise from external factors (*hetu*), such as the change of seasons, excesses in daily habits, accidents, or violent actions and individual behaviour. This system is presented, for example, in SN 36.21, where all these causes are listed, though they also appear in other discourses. By consolidating this eightfold causality of illness, we have the following:

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Canon. The relationship between diet and health is evident from the moment Buddhism establishes a correlation between foods and humours. For example, a brief sutta dedicated exclusively to *yāgu*, a food likely made from rice gruel (AN 5.207), lists the benefits of this food, including three of particular medical interest: the calming of the windy humour (*vātaṃ anulometi*), the purification of the bladder (*vatthiṃ sodheti*), and the food's digestive properties (*āmāvasesaṃ pāceti*).

61 Zysk, 'Doṣas by the Numbers', 5.

62 Wujastyk, 'The Science of Medicine', 38.

Humoral group
1. Bile (*pitta*)
2. Phlegm (*semha*)
3. Wind (*vāta*)
4. Colligation (*sannipātaka*)

Non-humoral group
5. Seasonal variation (*utu*, *utupariṇāmajāni*)
6. Extremes (*visamaparihara*)
7. External agency (*opakkamika*)
8. One's actions (*kammavipāka*)

As I noted in a previous study,[63] the presence of seasonal variance is another commonality with Hippocratic medicine, as is the prevention of life's excesses, a fundamental medical principle likely referring to diet,[64] moderate food consumption, and the proper selection of food, as well as other daily habits.

Regarding the term *opakkamika*, it should be mentioned that in addition to external influence, as translated by Zysk,[65] this term is perhaps more generally related to accidents. In connection with *ābādha*, it frequently appears to mean sudden, spasmodic or acute illness, but it also curiously appears in the suttas in connection with *vedanā*. Depending on the context, the expression *opakkamika* can also be understood as self-induced pain or as external violence (i.e., external attack).

## 6. The Ontological Foundation: Origin of Humoral Theory?

From this point forward, we will address the question concerning the origin of Buddhist medical thought. As is evident from our discussion hitherto, it is plausible that Buddhism did not invent its medical

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[63] Divino, 'Elements of the Buddhist Medical System'.

[64] See Περί διαίτης οξέων, (*Perí diaítēs oxéōn*; Regimen in Acute Diseases).

[65] Zysk, 'Doṣas by the Numbers'.

thought in India but rather innovated it based on pre-existing traditions. These traditions, possibly part of the knowledge shared among itinerant ascetics, are somewhat distinct from the Vedic model, though not entirely.

The theory of humours, which is the most original element of this system, cannot be explained merely as an innovation arising from nothing. It must necessarily be the result of some form of reflection based on pre-existing models of thought. When we examine similar medical theories in other cultures, such as Greek thought where we also find a humoral theory, we cannot avoid recognising that these formulations always stem from original ontological inquiries. Medical thought, in various cultural contexts, is consistently integrated into a framework that can be described as 'philosophical'. It is an integral part of the history of thought, specifically the part that begins to concern itself with questions concerning material substances, basic elements, their interactions and their role in constituting the human body and its functioning, including its health.

I conventionally refer to this reasoning as the 'ontological basis' of medical thought. Rather than being merely a foundation, in the Indian medical structure, as well as in Greek and medieval European medicine, this system is fully embedded within the philosophical context. Here, it plays a prominent role in contributing to broader reflections. In other words, medicine is always situated within a framework of philosophical inquiries, and Buddhism, which essentially relies on medical reasoning as the basis of its discourses on overcoming *dukkha*, is no exception in this panorama.

Regarding the theory of humours, there are various hypotheses about their origin. My suggestion is that it developed in a manner similar to what we can observe in Greek and medieval European thought, namely, starting from a search for the so-called *prīma māteria* ('prime matter').

Greek thinkers sought the concrete origin of what exists as the basis of phenomena and mere matter, which automatically reflected on medical thought and considerations regarding the relationship between the constituents of the human body and its health. Thus, the relationship between these basic constituents influences the potential onset of diseases. To a certain extent, we are thus led to hypothesise

that ontological reasoning underlies the basic principles of medical theory. Therefore, in relation to the theory of humours, we must attempt to explain the development and manifestations of that 'prime matter' that even Indian thought sought to explore.

In Greek medical tradition, this 'ontological basis' is clearly articulated.[66] In the book Περί φύσεως ἀνθρώπου (*Perí phúseōs anthrṓpou*, On the Nature of Man), Hippocrates himself asserted that humours (χυμός) should be considered essential elements of the human body, and in doing so, he used the terms ἐὼν and ὄντα, which are connected to ὄν, 'being' (all terms derived from εἶναι). Hippocrates spoke of the manifestation of the humours (four in his tradition, as they include blood and two types of bile instead of wind) 'according to law and according to nature' (ἀποφανεῖν αἰεὶ ὅ ταὐτὰ ἐόντα καὶ κατὰ νόμον καὶ κατὰ φύσιν' φημὶ δὴ εἶναι αἷμα καὶ φλέγμα καὶ χολὴν ξανθὴν καὶ μέλαιναν). In several instances, Hippocrates' ontological intent to connect the behaviour of humours to the phenomenal nature of the world is evident. In the Περί Διαίτης (*Perí diaítēs*) Hippocrates spoke of the elementary composition of humans as something ἐξ ἀρχῆς ('primal', 'original', and 'archetypal'), a concept comparable to the conception of the basic elements constituting everything found in the world and in the human body according to Buddhist theory. The term *dhātu*, used to describe these basic 'elements', is actually something 'given', 'put into place' (*dhā-*), a 'layer', a 'stratum' or a 'constitutive element'. The Buddhists refer to these gross elements also with the term *bhūtas*, which confirms that this is an ontological conception (*bhū*, 'to be', related to the Greek φύω, 'to grow').

Let us now examine the relationship between humours and the body in Buddhism. The windy humour (*vāta*) is clearly connected to breath and thus to air. It is important to consider that suttas such as those found in MN 28 go beyond simple humoral classification, listing four elements (*dhātu*) as components of the body's physiological constitution.[67] Among these is air (*vāyo*), described as airy or windy (*vāyogataṃ*). Similar to humours, each element has a preferred loca-

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[66] Enache, 'Ontology and Meteorology in Hippocrates' *On Regimen*'.

[67] See also SN 12.62, AN 5.162 and DN 22.

tion within the body, and its displacement can cause several issues. This displacement involves both their correct positioning in specific organs or body regions and their being 'internal' or 'external' (*ajjhattikā/bāhirā*).

Notably, there is an overlap between the humour *vāta* and the element *vāyo*. Every humour is quite ubiquitous, as it can be either internal or external (*vāyodhātu siyā ajjhattikā, siyā bāhirā*). What is even more interesting is how MN 28 treats the terms vāta and vāyo as essentially interchangeable. For instance, it states, 'The winds move up or down, the winds in the navel or in the bowels, the winds flowing along the limbs, inhalations and exhalations, all that is air, airy and properly internal, pertinent to the subject' (*uddhaṅgamā vātā, adhogamā vātā, kucchisayā vātā, koṭṭhāsayā vātā, aṅgamaṅgānusārino vātā, assāso passāso iti, yaṃ vā panaññampi kiñci ajjhattaṃ paccattaṃ vāyo vāyogataṃ upādinnaṃ*). Thus, note the interchangeability of *vāyo* and *vātā* in this section.

We then encounter another issue. Air is among those elements that can be either internal or external. All elements are essentially presented this way: they are the same elements (fire, water, air, and earth) that constitute the phenomenal world and can thus be found both externally (in the world) and internally (in the body). However, concerning human health, it is preferable when they are internal (*ajjhattaṃ paccattaṃ .... upādinnaṃ*).[68]

There is another possible way of classifying the elements, that is, whether they participate in the construction of internal organs. In

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[68] In MN 62, a similar list is proposed, introducing each element as 'both internal and external' (*siyā ajjhattikā, siyā bāhirā*), with the exception of the earth element. For the earth element, it is directly stated that it is 'internal' and 'connected to all that is solid, hard, and appropriate to be internal, pertinent to an individual' (*ajjhattaṃ paccattaṃ kakkhaḷaṃ kharigataṃ upādinnaṃ, seyyathidaṃ*). However, it is also mentioned that there exists an external earth element, which is not in any way different from the internal earth element (*yā ceva kho pana ajjhattikā pathavīdhātu yā ca bāhirā pathavīdhātu, pathavīdhāturevesā*). This equivalence between internal and external pertains to all other elements as well.

this context, we observe that earth has the greatest prevalence, being the element solely responsible for the formation of head hair, body hair, nails, teeth, skin, flesh, sinews, bones, bone marrow, kidneys, the heart, the liver, the diaphragm, the spleen, the lungs, intestines, mesentery, undigested food, faeces, and everything solid and hard within and pertaining to an individual (*kesā lomā nakhā dantā taco maṃsaṃ nhāru aṭṭhi aṭṭhimiñjaṃ vakkaṃ hadayaṃ yakanaṃ kilomakaṃ pihakaṃ papphāsaṃ antaṃ antaguṇaṃ udariyaṃ karīsaṃ, yaṃ vā panaññampi kiñci ajjhattaṃ paccattaṃ kakkhaḷaṃ kharigataṃ upādinnaṃ*). This should be kept in mind, as earth is the only element that is 'corporeal' in the 'organic' sense. The only other element that seems to constitute something 'physical' in the body is water, which plays a decidedly minor role as the basis of just body fat (*medo*), a fact that is essentially negligible when considering the preponderance of earth. Furthermore, as Köhle pointed out, there is a significant convergence between the Buddhists' lists of body parts and the primary and secondary digestive products of Āyurvedic theory.[69]

This classification already raises some doubts, as one group, that comprising organs and body parts, is composed of a single element. Furthermore, we observe that the remaining three—water (*āpo*), fire (*tejo*), and wind (*vāyo*)—which are considered both internal and external elements but should properly reside within the body, comprise three elements as three are the humours. This equivalence is not only due to the interchangeability of wind and air but also because fire and water are assimilable respectively to bile and phlegm according to some theories that postulate an original system of just two humours that excludes wind. However, in suttas like MN 28 and 62, water is related to both bile and phlegm. I will try to explain this apparent contradiction.

The hypothesis I propose here is that in the system of four elements constituting the human body, earth (*pathavī*) actually represents the physical and organic aspects and the body is a container (i.e., a 'solid' and 'stable' aspect). These aspects are also presented as

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[69] Köhle, 'Confluence of Humors', 481–82.

characteristics of the element 'earth' (*kakkhaḷaṃ-kharigataṃ*). For this reason, earth constitutes a category by itself, as an exclusively solid element.[70]

The other three elements have roles much more akin to humoral functions. For example, fire is exclusively connected to digestion (*pariṇāma*). In Āyurveda, the humour *pitta* is also linked to the digestive process, which, as we will see, might not be a coincidental association.

While the equivalence between *vāta* and *vāyo* is explicit, in MN 28 and MN 62, water is connected to both bile and phlegm. I believe this connection arose after the tri-humoral medical theory and is inspired by the liquid and fluid nature of water (*āpo āpogataṃ*) that is subsequently applied to the two humours. Specifically, bile, phlegm, pus, blood, sweat, fat, tears, grease, saliva, snot, synovial fluid, and urine (*pittaṃ semhaṃ pubbo lohitaṃ sedo medo assu vasā kheḷo siṅghāṇikā lasikā muttaṃ*) are all connected to water, possibly for the same reason. We see that water does not contribute to the physical construction of organs but is rather a constituent similar to a humour: the presence of blood and other fluids is crucial in this regard. However, the humours *pitta* and *semha* are also considered fluids, which, at least in the case of *pitta*, could represent a later shift, as I hypothesise that originally, the bilious humour was associated with fire. A subsequent identification of bile with gastric juice would elucidate the transition of bile to align with a liquid conception. Given that this specific humour was possibly originally associated with fire due to its peptic-digestive function, it is likely that, for prag-

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[70] I would like to take this opportunity to correct a potentially misleading passage in one of my previous publications on the subject (Divino, 'Elements of the Buddhist Medical System'). In that instance (40, Table 2), I did not make it explicitly clear that all four elements are presented as both internal and external and that in their internal manifestation (within the body), they are considered healthful. The way I adjusted the table seems to suggest that the *pathavī* element is presented as solely internal, but this is not the case. What I intended to emphasise instead was the association between this element and the constitution of the body's organs.

matic reasons, when greater attention to physiology and anatomy recognised the same function in gastric juices, there was an immediate association with bile, thereby transforming it into a 'liquid' humour.[71]

Regarding the origin of the humoral theory, Wujastyk traced it back to the Vedic world, suggesting that instead of a triadic model, it was initially dualistic.[72] The two original humours would only be bile and phlegm as outcomes of the ancient Vedic dualism between *agni* and *soma*, which, besides being constituents of matter, would also be fundamental elements (*dhātu*) of the human body and its functions, such as digestion, which employs a fiery power.[73]

Therefore, we should expect this binary nature to also be the common origin of the theory of *guṇa*, and there are indeed indications in this regard.[74] Additionally, these would have subsequently

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[71] Today, we still use the expression 'bile reflux', when bile juice from the liver backs up into the stomach and gets mixed with the gastric juice in the vomit. Phlegm, however, is connected to the mucous membranes (see e.g. DN 14, ... *udena amakkhito semhena amakkhito ruhirena*...) and seems to be considered a condensation of water and therefore connected to the element of water.

[72] Wujastyk, 'Agni and Soma'.

[73] If this theory is correct, it would find validation in its comparability with the foundations of Hippocratic medicine, in which fire and water are the only two basic elements that construct the Hippocratic ontology (πυρὸς καὶ ὕδατος) and, by extension, its medical theory. The notion that Hippocratic medicine is fundamentally the development of an ontology is demonstrated by Cătălin Enache in Enache, 'Ontology and Meteorology in Hippocrates' *On Regimen*'. Should Buddhism have followed a similar developmental pattern, partly due to the shared Indo-European cultural and intellectual milieu, it would further support our ontological theory. Enache translated the opening of Chapter 1.3 of Hippocrates' Περί Διαίτης (*Perí diaítēs*) as follows: 'Every living being, including man, is composed of two [elements], fire and water, which differ in power but cooperate in their activity' (*συνίσταται μὲν οὖν τὰ ζῷα τά τε ἄλλα πάντα καὶ ὁ ἄνθρωπος ἀπὸ δυοῖν, διαφόροιν μὲν τὴν δύναμιν, συμφόροιν δὲ τὴν χρῆσιν, πυρὸς καὶ ὕδατος*).

[74] Przyluski, 'La Théorie des Guna'.

became three, with the *sattvic* characteristic as the third insertion, derived simply from the existential quality (*sattva* from *sat-*, 'being'). This would explain why it is the only *guṇa* in medicine that presents no negative aspect. If this is true, ancient Buddhist medical formulations would not have non-Indo-European roots. I assert that this does not hold true. Its origin would at least be the result of interaction between endogenous and exogenous thoughts on Indo-Aryan traditions.[75]

Whatever the origin of the third humour, we must inquire whether there are indications in the Pāli Canon to suppose that the tri-humoral formulation was derived from an older binary between *agni* and *soma*, or even, as Angermeier suggested, between hot and cold.[76] The hot/fiery aspect is undoubtedly associated with the digestive process.

The triad of bile–fire–digestion appears not only again in Āyurveda but also in later Buddhist medical treatises such as the *Bhesajjamañjūsā*. However, it could be argued that the latter is clearly a rewriting of Buddhist medicine based on Āyurveda. In fact, careful analysis of the text appears to substantially cite Āyurvedic treatises for more than half of its content.[77]

The 'contamination' of water as a fluid archetype in humoral theory as a subsequent interpretation, however, seems to be a fact supported also by Āyurvedic theory itself, where the three humours

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[75] There would indeed be the intrusion of a third humour, the windy one (*vāta*), which appears perhaps connected to the importance that breathing has in ascetic traditions as a vital force (*prāṇa*) and the exercises based on it as anthropotechnics (Zysk, 'The Bodily Winds in Ancient India Revisited'). Furthermore, the possibility of this element's Indo-European origin is also a sustainable hypothesis by virtue of the existence in the Hippocratic corpus of texts like Περί φυσῶν (*Perí phusôn*, On Breaths), where pathologies caused by breath (φῦσαι) are also discussed. Breath (πνεύματα) also appears as one of the three forms of sustenance for human and animal bodies (τὰ γὰρ σώματα τῶν τε ἀνθρώπων καὶ τῶν ἄλλων ζώων ὑπὸ τρισσέων τροφῶν τρέφεται), together with σῖτα and ποτὰ.

[76] Angermeier, 'Agni and Soma Revisited'.

[77] Divino, 'Elements of the Buddhist Medical System', 23.

are explained as the interaction of multiple elements. Nevertheless, beyond the windy humour (*vāta*), which essentially unites two variants of the same concept of air (*ākāśa* + *vāyu*), what appears curious is the presence of water both in bile (*pitta*) and in phlegm (*kapha*). The former is the union of water and fire (*agni* + *āpas*) and the latter of water and earth (*pṛthvī* + *āpas*).[78]

In this sense, suttas such as MN 28 or 62, where we already begin to see water associated with the two humours, would be subsequent phases, intermediate between the first humoral theory and Āyurveda.

The fluidic nature of bile and phlegm is frequently mentioned in the suttas. Although we do not know precisely what these two humours were associated with in the minds of Buddhists, it is likely that they were related to the digestive process, particularly *pitta*. Both bile and phlegm can be vomited in conditions of poor bodily health. One example that mentions this possibility is Snp 1.11, which discusses the body in general. This segment can also serve as an example of the anatomical attention of the Buddhists.

Initially, the body is examined in all its possible movements: standing, sitting, lying down and with limbs extended and contracted, such are the movements of the body (*caraṃ vā yadi vā tiṭṭhaṃ, nisinno uda vā sayaṃ; samiñjeti pasāreti, esā kāyassa iñjanā*). Then, the body is examined from the inside: it is held together by bones and sinews (*aṭṭhinahāru-saṃyutto*), with a plastering of flesh and skin covering the body (*tacamaṃsāvalepano chaviyā kāyo paṭicchanno*) so that we do not see it as it truly is (*yathābhūtaṃ na dissati*). The contents of the body include the stomach and intestines (*antapūro udarapūro*), liver and bladder (*yakanapeḷassa vatthino*), heart, lungs, kidneys, and spleen (*hadayassa papphāsassa, vakkassa pihakassa*). The fluids include nasal mucus and saliva (*siṅghāṇikāya kheḷassa*),

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[78] If this holds true, the omnipresence of water is derived from the association with the fluid nature of phlegm and bile, but originally, the only aqueous humour was phlegm, to which the interaction with earth was added to balance the fact that the fiery humour, bile, was also associated with water to explain its fluid nature. This would have necessitated making each humour the union of two different elements to balance the theory.

sweat and fat (*sedassa ca medassa ca*), blood and synovial fluid (*lohitassa lasikāya*), bile—the first humour mentioned—and grease (*pittassa ca vasāya ca*).

The sutta continues by listing various impurities that flow within the body, such as eye discharge and earwax, and it further states, 'the mouth sometimes vomits bile and phlegm' (*pittaṃ semhañca vamati*). This discourse explicitly aims to lead the mendicant to reject desires towards the body (*kāye chandaṃ virājaye*), but it also shows that bile and phlegm were considered fluids capable of being vomited. In some way, the stomach must be involved.

Another indication that bile and phlegm behave like fluids is found in Snp 3.2: 'While the blood is drying up, the bile and phlegm dry too' (*lohite sussamānamhi, pittaṃ semhañca sussati*). These clues lead us to conclude that, even though we do not know if there was an ancient correspondence to specific bodily fluids known today, bile and phlegm were certainly treated as fluids by the Buddhists, as they can be vomited (*vamati*) and can dry up (*sussati*). However, by comparing Buddhist texts that contain body constituent lists and Āyurvedic theory, Köhle concluded that 'in contrast to the bile and phlegm of the body constituents lists, the bile and phlegm of the *tridoṣa* were perceived as constituent parts of an abstract triadic system that could manifest itself in the shape of a multitude of different functions, rather than as simple digestive fluids'.[79]

Bile and phlegm are emblematic humours. They often appear in pairs and in texts where the third humour is not mentioned. There is at least one notable case where only bile is mentioned, in the context of a metaphor. The sutta is SN 17.36, which discusses Prince Ajātasattu preparing to visit Devadatta with a substantial food offering. The Buddha advises the disciples not to envy Devadatta, as his riches will not increase his skilful qualities (*pāṭikaṅkhā kusalesu dhammesu, no vuddhi*), for they are merely material possessions that presumably increase the risk of attachment and are not beneficial for Devadatta. At this point, the Buddha makes a comparison: 'As if bile were to overflow excessively from the nose of a wild dog, this would

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[79] Köhle, 'Confluence of Humors', 482.

only make the dog more violent' (*seyyathāpi... caṇḍassa kukkurassa nāsāya pittaṃ bhindeyyuṃ, evañhi so, bhikkhave, kukkuro bhiyyoso mattāya caṇḍataro assa*). This is a clear metaphor about the dangers of excess, but it helps us understand the Buddhist conception of bile. Comparing it to the theory of four temperaments, an excess of bile is associated with the choleric temperament (from χολή, 'bile') in Greek humoral pathology.

Another interesting aspect of this medical theory is the association between different organs, likely sharing the domain of the same humour. AN 5.208 explains why it is appropriate to use chew sticks (*dantakaṭṭha*, likely medicinal wooden sticks chewed for dental hygiene). The failure to use them should affect only oral health; however, the Buddha states that the eyes would also suffer (*acakkhussaṃ*). This is curious unless we hypothesise that a principle similar to the correlation between organs found in Chinese medicine is being asserted.[80]

According to this principle, organs are related to each other, and imbalances in one organ reflect symptomatically in another. Here, the Buddha seems to affirm a similar idea: Poor oral hygiene affects the health of the eyes. The other symptoms are more easily understood: bad breath (*mukhaṃ duggandhaṃ*) and altered taste (*rasaharaṇiyo na visujjhanti*). There is also another consequence, namely the loss of appetite due to an excess of bile and phlegm covering the consumed food (*pittaṃ semhaṃ bhattaṃ pariyonandhati, bhattamassa nacchādeti*). Here again, bile and phlegm appear together, with no mention of the windy humour.

Buddhist medical thought, like Buddhism in general, has clear roots in the ascetic traditions of ancient India, and these traditions have always posed a challenge for scholars investigating their origins. On the one hand, thinkers such as Bronkhorst have perceived in these traditions a sense of uniqueness and peculiarity exogenous to the Vedic and Indo-Aryan traditions, concluding that this was an external contribution from pre-existing populations in the region that, through their interaction with the Indo-Aryans, entered into a

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[80] Lo, Stanley-Baker, and Yang, eds., *Routledge Handbook of Chinese Medicine*.

dialectical relationship with Vedic thought, thus forming a counterpoint to it.[81]

On the other hand, another group of thinkers, of which Olivelle is a notable contributor, believe that all the foundations of Indian ascetic thought can be traced back to the Vedas and Indo-Aryan priestly traditions.[82] This divergence is also evident in the understanding of medical traditions; the medical concepts recorded in the Pāli Canon are clearly at odds with those of the Vedas. The opposition between magico-religious medicine (Vedic tradition) and empirical-rational medicine (ascetic and Buddhist traditions) as outlined by Zysk reflects this difference.

However, does this necessarily imply an exogenous origin for the Buddhist medical tradition? One could argue that, despite their conflict with the Vedic system, ascetic thinkers derived their traditions entirely from the orthodoxy itself. For instance, concerning the anatomical attention showed by Buddhist texts, we should not exclude the possibility that this knowledge was indeed a derivation of Vedic tradition, where anatomical familiarity was already established and 'derived principally from the sacrifice of the horse and of man; chance observations of improperly buried bodies and examinations of the corporal members made by medical men during treatment'.[83]

Also, Vedic medicine was not completely 'non-empirical' or 'non-rational', since Zysk himself pointed out that the texts show 'a systematic, classificatory way of thinking' and thus 'Vedic healers showed that they were familiar with more empirical procedures of healing'.[84] The point made by Zysk concerns primarily the 'context' of Vedic medicine, which is 'the magico-religious rite', that is, the idea that the efficacy of a certain medicament is inextricably linked to a certain formula (utterances or mantras), a ritual, or a magical or spiritual operation. For instance, this is quite absent in the medical vision found in the Pāli Canon.

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[81] Bronkhorst, *Greater Magadha*.

[82] Olivelle, *The Āśrama System*; *idem*, 'Village vs. Wilderness'.

[83] Zysk, *Medicine in the Veda*, 7.

[84] Ibid., 10.

The existence of advanced populations and cultures in the Indian subcontinent prior to Indo-Aryan migrations is well established,[85] and it is also plausible that aspects of yogic and ascetic traditions were indeed borrowed from (or significantly influenced by) these populations.[86] One hypothesis does not exclude the other; it is a lengthy process of dialectical engagement and conflict between orthodoxy and heterodoxy, where exogenous conceptions may have played a role, but the construction of heterodoxy does not necessarily represent a uniqueness alien to orthodoxy.[87] Many Buddhist concepts are in fact value inversions of Vedic concepts.[88] This also applies to words like yoga (in the variant *yuga*)[89] and *śramaṇa* (through the root √*śram*),[90] which were already present as terms in the Vedas but were gradually reformulated—perhaps through the influence of another tradition?—transformed and evolved. Vedic thought may have been the foundation for many concepts inherited from ascetic traditions, which does not preclude the field of dialectical conflict nor the contribution, in some form, of non-Indo-Aryan traditions. However, this insight helps us better understand this very conflict.

One could argue that Buddhism rejects the idea of a prīma māteria in the sense analogous to the Greek ἀρχή or a primordial unconditioned condition such as the pradhāna of Sāṃkhya thought. There is a general assumption of fierce rivalry between Sāṃkhya thought and Buddhism, which I do not fundamentally share.[91] There are numerous reasons to believe that Early Buddhism accepted the idea of a first principle and that the concept of *anattā*, the factual predecessor of 'emptiness',[92] pertains to perceptual issues regarding

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[85] Parpola, *The Roots of Hinduism*.

[86] McEvilley, 'An Archaeology of Yoga'.

[87] Squarcini, '*Pāṣaṇḍin*, *vaitaṇḍika*, *vedanindaka* and *nāstika*'; *idem*, 'Tradens, Traditum, Recipiens'; *idem*, *Tradition, Veda and Law*.

[88] Divino and Di Lenardo, 'The World and the Desert', 143, 149–53, 159.

[89] Squarcini, 'Introduzione', xiii.

[90] Shults, 'A Note on Śramaṇa in Vedic Texts'.

[91] Divino, *Il Sāṃkhya Perduto*.

[92] Vélez de Cea, 'Emptiness in the Pāli Suttas'.

the self-subsistence of entities. Early Buddhism essentially rejected the notion of an autonomous and independent entity—an identity existing independently of the web of interdependence. However, this substantial emptiness or voidness, resulting from the awareness of the non-identity of things that appear identical but are, in fact, interdependent, does not imply that things are 'nothing' or lack 'substance'. Rather, they have 'non-independent substantiality'.[93]

The idea of *anattā* does not preclude that of a *prīma māteria* or, as they refer to it, an absolute and primary principle (*aggaññ a*): the simple being (*satta*) or truth (*saccā*, a term derived from *sat-*, 'being'), even in the form of 'what is' (*yathābhūtaṃ*). Finally, though it is more controversial to argue, a fundamental 'sense' (*attha*, *aṭṭha*) and an 'ultimate sense' (*paramattha* < *parama-attha*, *uttama attha*) can be posited as well.[94]

In DN 27, we find discourse on the primary principle (*aggaññ a*, 'that which came first'). Although this discourse is often viewed as a parody of Vedic genesis,[95] depicting 'an open challenge to the Vedic dogma of the divine creation of the social order',[96] from this sutta, it is clear that Buddhism acknowledges a primary principle to justify the decline of humanity into ignorance. Buddhism recognises a primary principle and a time when it was undivided and undifferentiated, devoid of attributed nominal identities—a time when 'essences were simply beings' (*sattā sattātveva saṅkhyaṃ gacchanti*).[97] Here, 'simple being' is the *prīma māteria*, which retreats to no longer being known simply as 'being' due to the paradigm of division. Given the terminological coincidence, we can also translate it as 'beings were known simply as "beings"' (*sattā sattātveva*), literally 'their name went as' (... *saṅkhyaṃ gacchanti*) simply 'being' (*satta*). Note also the use of the term *saṅkhya* to

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[93] Divino, 'Dualism and Psychosemantics'. See also Brown, 'Microgenesis and Buddhism', 264. See also Vélez de Cea, 'Emptiness in the Pāli Suttas'.

[94] Divino, 'An Anthropological Outline of the Sutta Nipāta', 6–11.

[95] Gombrich, *How Buddhism Began*, 81–82.

[96] Chakravarti, *The Social Dimensions of Early Buddhism*.

[97] Divino, *The Apparent Image*, 189.

indicate conceptualisation, the Pāli equivalent of *sāṃkhya*. This discourse denounces the corruption of the *prīma māteria* through perceptual deceptions, where *sattā* is no longer *sattā* but known as something else. This 'something else' comprises names and identities that proliferate. As such, names become associated with forms, and the search for essences results in the attribution of nominal identities. This major theme, while exceeding the scope of research related to the history of medical thought, is relevant here: being is essentialised and multiplies into essences and constituents that combine, creating the phenomenological theatre for both the five aggregates and the three humours.[98]

Other interesting aspects to consider in DN 27 include the critique of the concept of purity. Buddhist medical theory is also an attempt to reclaim bodies subjugated by the Vedic order to a moral system that bound them to behavioural norms under the pretext of purity. In the Vedic world, the device of purity was used to justify the adherence of social bodies to ethical norms. In DN 27, as in many

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[98] I use the expression 'phenomenological theatre' to imply the phenomenological discourse by virtue of the same Buddhist terminological choice. When it is stated in DN 27 that beings manifested or appeared only as 'beings', the text uses the term *saṅkhyaṃ* and says '*sattā* (beings) *sattātveva* (as simply beings) *saṅkhyaṃ* (by definition) *gacchanti* (went)'. The term *saṅkhyaṃ* indicates definition, conceptualisation or even enumeration (i.e., category). It consists of two main parts: the prefix *saṃ-*, which means 'put together', and the root √khyā, which is an extremely fascinating term. In its more general usage, it indicates 'to be named' or 'to be known', or even 'to be announced', from which the extended meaning of 'to be famous', 'of fame', and 'renowned' derives (see e.g., the Sanskrit *khyāti*). In the philosophical context, one could construct a discourse solely on this root, since there also exists the thought of *khyātivāda* concerning discourse on perceptual errors or misconceptions. The term, therefore, has to do with appearances and designations. Possibly also related to *kāś* (< **kweḱ-* 'to see'), which indicates being 'visible' or 'appearing', the term also conveys an idea of 'shining'. With this, it shares with the Greek φαινόμενον the luminous nature (φαίνω) that metaphorises the appearing in the discourse about the origin of things.

other suttas, the idea of purity tied exclusively to the performance of certain rituals or belonging to certain social classes is entirely rejected. The Buddha specifically highlights the paradox of social classes, such as the *khattiyā* and *brāhmaṇā*, who, despite boasting of being purer than others, commit impure acts like killing living beings (*pāṇātipātī*) or engaging in sexual misconduct (*kāmesumicchācārī*). This criticism aims to deconstruct the idea of purity as a biopolitical device, rejecting all categories in general and referring to an ideal time when sentient beings possessed mental bodies (*manomayā*), emitted their own light (*sayaṃpabhā*) and enjoyed a divine nature. This ideal and initial state is followed by a decline, passing through the acquisition of gross bodies (*kharattañceva kāyasmiṃ*), nutrition, corruption, and differentiation.

Originally, even distinctions between males and females did not exist (*na itthipumā paññāyanti*), nor was there a sun and a moon (*na rattindivā paññāyanti*). Rather, there was a vast mass of dark water (*andhakāro andhakāratimisā*), perhaps a reminiscence of a Vedic myth where the waters of the cosmic ocean preceded even Agni, the most important deity of the Ṛgveda, which itself emerged from these waters, earning the title of *apām napāt*.[99]

The myth in DN 27 depicts a progressive degeneration of beings towards essence and differentiation, with this decline occurring through eating. Gradually from the waters (and later from the earth emerging from them), things like sweet nectar, a mushroom, bursting pods, and rice appear. Primordial beings, feeding on these foods, progressively lose their divine characteristics, first their light (*sattānaṃ sayaṃpabhā antaradhāyi*) and eventually acquiring gross bodies, gender differences, and the perception of being beautiful or ugly, though they lament the taste of the food that corrupted them, saying wistfully, 'oh that taste!' (*aho rasaṃ*). Interestingly, the term rasa, indicating taste, also has another meaning: 'essence'.

This sutta, in summary, does not discuss medicine but a fundamental concept related to thinking, linking the Buddhist conceptions

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[99] Magoun, '*Apām Napāt* Again'; Bodewitz, 'The Waters in Vedic Cosmic Classifications'; Findly, 'The "Child of the Waters"'.

of the body, purity and corruption, all within the idea of a primordial essence that has lost its balance and light. However, as mentioned earlier, this sutta is parodic in relation to Vedic tradition, from which it drastically diverges. Here we reach another fundamental point, completing the circle concerning the birth of the figure of the physician, that is, the dialectical clash between the Vedic and ascetic views.

## 7. Order and Wholesomeness: Clashing Medical Conceptions

We conclude this examination of medical thought in Early Buddhist tradition with some considerations. We have observed how Buddhism, since its inception, is grounded in medical considerations and exhibits an attentiveness to the world akin to that of a physician. Moreover, the role of the physician as a distinct social function—specifically concerned with illness and its treatment—takes a well-defined form within Buddhism, facilitated notably by the formulation of comprehensive medical theories, the most significant of which pertains to bodily humours.

The genesis of Buddhism's medical interest warrants inquiry. The hypothesis posited here is that it largely emerged as a consequence of dialectical confrontation with the Vedic milieu, necessitating a radical re-evaluation and reformulation of issues pertaining to health and illness. Thus, it encompasses not merely the transmission of medical knowledge as a form of wisdom, although this aspect is undeniably pivotal: 'these wanderers sought and acquired a variety of useful information of which medicine was a significant component'.[100] Yet, what unequivocally proves decisive, we may now assert, is the dialectical relationship with tradition, wherein the conception of health and illness not only diverged radically but also served to enforce a social order. In opposition to this paradigm, which advocated a magical-religious approach to therapy, as articulated by Zysk, Buddhists introduced a critical, empirical-rational perspective. This stance not only countered the 'biopolitical' application of medicine but also

[100] Zysk, 'New Approaches to the Study of Early Buddhist Medicine', 149.

fostered its original and innovative development. Consequently, the fundamentally distinct notion regarding the utilisation of bodies emerged.

It is imperative to bear in mind that medical culture inherited its ideas of care and therapy, which, however, were rooted in an entirely different model; there did not exist the figure of a 'physician' as a professional of illness. Rather, medical capacity was embodied by sacred operators, proposing a medicine in which 'healing may be conceived broadly in terms of magical rituals during which specialized priests exorcised demonic diseases by means of spells and amulets or other apotropaic devices'.[101] This view of illness remained predominant even in Brahmanism, thus creating a gap, according to Zysk, between the more empiricism-based medicine advocated by Buddhists and the magical-religious medicine of the Vedic tradition.

This shift corresponds to the evolving positions of Indian medicine as described by Zysk. In the earliest, or Vedic, stage of Indian medicine, diseases were connected to divine punishment or sorcery, whereas in the second stage, the humoral theory came in. This conception 'has no antecedents in Vedic medicine',[102] and this is why it is difficult to determine its origin. What differs the most however is not just the conception of the disease but also the consequence of this epistemology, which led to the emergence of the physician as a specialised figure capable of dealing with *roga* or *vyādhi* (P. *byādhi*).

To summarise, the Pāli Canon is significant for studies on Buddhist medicine not only because it provides the earliest attestation of Indian humoral theory, which is more systematically mentioned in later Āyurvedic texts, but also because these ancient texts bear witness to at least two other important aspects: medical knowledge involving particular attention to anatomy and the body and the use of medicine as a metaphor to convey Buddhist teachings, thereby fostering deep reflection on the role of illness. Additionally, these texts testify to the existence of a distinct role for a 'physician', which, although partly linked to the ascetic role, remained separate. Buddhism, in fact,

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[101] Zysk, 'Does Ancient Indian Medicine', 80.

[102] Ibid., 85.

possesses intricate medico-anatomical knowledge that is too detailed to be coincidental, often employing it as an explanatory device to expound its doctrines. Buddhism, which opposes social hierarchies (Snp 1.6) that justify worldly order through medical expedients (such as the purity of higher classes), skilfully uses the same tool. In Ud 3.10, identity is defined as a disease ('this disease, which is identity', *roga attato*). The concept of disease (*roga*) is opposed by its antithesis (*aroga*), mentioned as early as Snp 4.4, and is therefore likely to be quite ancient.[103] In this text, the concept of aroga is connected to that of purity (*suddha*).

Suffering (*dukkha*) is, as previously mentioned, one of the most important concepts in early Buddhist thought. It is addressed as a disease but is fundamentally different from *roga*/*ruja*. While the latter denotes a dysfunction in a technical sense, *dukkha* is a generalised malaise and therefore an existential disease.

The body is a focal point in the discourses of the Buddha on multiple occasions. It is dissected, dismembered and analysed for its every part, with its organs enumerated and its elements compared to external problems.[104] Beyond the subsequent developments of this idea, it must be noted that Buddhism seems to partially share the traditional conception that views the body as an epicentre of potential impurities (*aparisuddhakāya*), not because it rejects fluids and secretions, as is the case in Brahmanism, but rather because it considers the four elements constituting the body to be inherently impure. However, this condition does not represent a condemnation.

Certainly, far from advocating a rigid and punitive asceticism, Buddhism has always promoted an idea of the body that is much more aligned with health: 'health and a good digestion are among qualities which enable a person to make speedy progress towards enlightenment'.[105] This should be considered in a context where ascetic practices are generally associated with austerity or even a total neglect of bodily care. We must remember that dualism is opposed

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[103] Divino, 'An Anthropological Outline of the Sutta Nipāta', 2–3.

[104] Zysk, *Asceticism and Healing*, 34–37.

[105] Harvey, 'The Mind-body Relationship in Pāli Buddhism', 29.

in all its extremes, but the idea of impurity is not abandoned; rather, it is used to challenge the very dualistic conception of pure/impure, transitioning from being a mechanism of bodily control to a way of indicating how to escape normativity. Only in this context can we understand discourses such as the one found in SN 4.1, where the practice of mortification, quintessentially ascetic, is denigrated as 'impure', while simultaneously critiquing the dualistic idea that includes the pure/impure axis promoted by the same ascetics practising mortification: 'You [addressing the Buddha] have departed from the practice of mortification by which humans purify themselves; you are impure but consider yourself pure, you have lost the path of purity' (*tapokammā apakkamma, ye na sujjhanti māṇavā; asuddho maññasi suddho, suddhimaggā aparaddho*). With these words, Māra, lord of death, attempts to mislead the Buddha, who remains unfazed: 'I have understood that it is useless; all mortification in search of immortality is futile, like oars and rudder on dry land' (*anatthasaṃhitaṃ ñatvā, yaṃ kiñci amaraṃ tapaṃ; sabbaṃ natthāvahaṃ hoti, phiyārittaṃva dhammani*). Yet, the idea of purity is not renounced; rather, it is reclaimed and turned against the interlocutor: 'Morality, concentration, and wisdom; by developing this path to awakening I have attained ultimate purity, and you are defeated, O eradicator' (*sīlaṃ samādhi paññañca, maggaṃ bodhāya bhāvayaṃ; pattosmi paramaṃ suddhiṃ, nihato tvamasi antakā*).

Although excessive ascetic rigor is criticised, the fundamental point remains: 'It is possible to go beyond this entire realm of perceptions' (*atthi imassa saññāgatassa uttariṃ nissaraṇaṃ*, MN 7), thus maintaining the idea that illness stems from erroneous perceptions and that there is a link between error and impurity. In the sutta dedicated to the benefits of the ascetic path (DN 2), success in the *jhāna* practice is connected to the notion of ultimate purity (*parisuddha*). This text not only features the physician Jīvaka but also presents numerous metaphors related to purity and medicine. The ascetic is compared to a lotus flower, which surfaces while its roots are nourished underwater; similarly, the meditator immerses in asceticism to the extent that 'not a single part of his body is untouched by pure and clear mindfulness' (*nāssa kiñci sabbāvato kāyassa parisuddhena cetasā pariyodātena apphuṭaṃ hoti*). Thus, we observe the emergence

of the idea of an ultimate 'purity' (*pari-suddha*) directly linked to the fruits of asceticism.

This figure is, in some respects, legendary and is also mentioned in the eighth chapter of the Mahāvagga. It is said that the Buddha fell ill with a humoral imbalance (*kāya dosābhisanna*); his personal physician, Jīvaka Komārabhacca, applied therapeutic ointments to the Buddha's body and administered a lotus-flower-based purgative (*virecana*). After repeating the procedure as necessary, the physician advised the Buddha to drink a broth prepared from alms food (*yūsapiṇḍa*). This type of therapy can be considered an emetic (*vamana*) treatment, as its purpose is to remove impurities from the body. This episode, besides being further evidence of the link between Buddhism and medicine, seems to emphasise the figure of Jīvaka, whose power is such that he could 'heal even the Buddha by means of a magical cure involving the inhalation of the fragrance of lotuses, plants nearly always associated with important personages in India'.[106]

These accounts, far from being mere representations, are for Zysk the earliest evidence of applied Āyurvedic therapies, such as the preparation of a drug (*pūrvakarman*), purification (*pañcakarman*) and final purification (*puścatkarman*). From this early attestation, a structured theory of humours emerges, as well as the possibility that they can become 'polluted'. The presence of this physician, whether mythological or real, certainly signals the significant importance that Buddhism placed on medicine. Indeed, the similarities between Āyurveda and medical practices cited in ancient Buddhist texts are numerous, starting with the emphasis on proper nutrition.[107]

In conclusion, we can assert that Buddhist thought presents important attestations for the history of Indian medicine. The Pāli Canon serves as evidence not only of a medical conception beginning to take autonomous shape, foreshadowing the rich Buddhist medical traditions and Āyurveda itself, but also as the foundational point from which an archaeology of medical thought must initiate poten-

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[106] Zysk, 'New Approaches to the Study of Early Buddhist Medicine', 147.

[107] Zysk, *Asceticism and Healing in Ancient India*, 41.

tial inquiries into Indian and Buddhist medical history. These texts contain profound medical reflections on the concepts of health and disease, interwoven with Buddhist doctrine. Additionally, they document the development of a medical practitioner figure emerging in constructive dialogue with the Buddhist ascetic while simultaneously engaging in a dialectical (and often confrontational) process with the preceding Vedic tradition, in which the roles of the physician and the understanding of disease differed and were opposed by Buddhist thought.

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### Abbreviations

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| AN | *Aṅguttaranikāya* |
| Dhp | *Dhammapada* |
| DN | *Dīghanikāya* |
| Iti | *Itivuttaka* |
| MN | *Majjhimanikāya* |
| SN | *Saṃyuttanikāya* |
| Snp | *Suttanipāta* |
| Ud | *Udāna* |

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