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Jainism's Evolving View of Medicine

In this chapter, we explore how Jain texts view physical and mental illness, as well as the rules and exceptions they propose regarding medical treatment. After exploring a range of factors that Jain texts consider to either directly cause or contribute to the occurrence of illness, we examine the approaches to medicine in the early strata of the Śvetāmbara canon. We argue that these early canonical texts open up space for the later use of medicine with emerging accommodations and a "duty to care" for the sick, and we discuss several factors that influenced the changing attitudes. Then we examine the liberalization of medicine in the later canonical and postcanonical periods, followed by an overview of some important medieval Jain medical treatises. We conclude by summarizing five Jain principles for medicine and medical care that arise through our analysis. We focus here on the general principles of Jain medicine, and on the medical treatment of mendicants in selected canonical and postcanonical texts up to the medieval period; we mention laity mainly in relation to the treatment of mendicants. Lay and contemporary mendicant attitudes to medicine will be discussed in more detail in part 2 of this book.

It should be pointed out that the history of Jain medicine has scarcely been researched. While some valuable textual studies have been conducted on illnesses, medical treatises, and the mendicant attitudes to medical treatment, contemporary mendicant attitudes to medical treatment and the history of the lay approaches to medicine, to our knowledge, remain largely unexplored. The Digambara sources are likewise less researched. This means that much work still needs to be done in order to gain a comprehensive insight into Jain approaches to medicine, their relationship with other Indian medical traditions, and their potentially unique developments. Our present examination is one contribution to that ongoing effort.

Because Jain texts reflect accommodations for mendicants and laity at diverse points of karmic and spiritual development, and these, further, express various historical, cultural, and social contexts, there is no single unified "Jain view" of

medicine. However, certain perspectives and values can be identified which may iluminate a Jain approach to medicine that informs an engagement with contemporary bioethical issues. As will be evident in this chapter and in part 2, several bioethical issues that arise for Jains today—despite bioethics being a relatively young discipline—are historically prefigured in the encounters between the Jain tradition and medicine.

WHAT CAUSES AN ILLNESS?

As explained in chapter 2, Jains believe that the embodiment of living beings who are trapped in the cycle of rebirths is determined by karma they have accumulated throughout their lives. Accordingly, Jain texts often explain illness—as a particular condition of the embodied state—in terms of karma (BhS 16.2§701b), but as we will discuss in the following sections, karma is not understood to be the only factor that causes it. While mainly exploring the factors that generate illness, this section also touches on the methods of healing, with a particular focus on their effectiveness in relation to the various underlying causes of ailments.

Physical Illness

In Jain cosmology, illness (*roga, vyādhi*)[1] affects only those human beings born in the "lands of action" (*karma-bhūmi*) of which our world is part. These humans are susceptible to aging and illness, unlike those born in the "lands of enjoyment" (*bhoga-bhūmi*) whose bodies do not age and who die naturally when their longevity-determining karma (*āyu-karman*) is exhausted.[2] While humans have several bodies, as discussed in chapter 2, illness affects only their principal body, which is the gross physical body (*audārika-śarīra*) (Wiley 2000a, 267).

More specifically, illness is considered an efficient or instrumental cause (*nimitta*) that harms the vitalities (*prāṇa*) of embodied beings. Among these, the principal one is the vitality of life (*āyu-prāṇa*), which is the product of longevity-determining karma. The others include the five sense vitalities, the vitality of respiration, and the vitalities of mind, speech, and body, all produced by name-determining karma (266–67).[3]

The efficient cause of illness itself is understood to be feeling-producing karma (*vedanīya-karman*), a nondestructive type of karma that is associated with the experience of pleasure and pain (*vedanā*), as explained in chapter 2. Śvetāmbaras and Digambaras both associate illness with the subtype of this karma that produces pain or unpleasant experience, called *asātā-vedanīya-karman* (TS 9.16; TVā 8.8.2; Wiley 2000a, 271).[4] Digambaras, further, maintain that the operation of certain other karmas makes the human body more prone to falling ill.

One such karma is the so-called *upaghāta-nāma-karman*, a type of name-determining karma that is thought to be always accompanied by pain-producing karma (Wiley 2000a, 271). As noted in chapter 2, Digambaras understand the

upaghāta-nāma-karman to be a factor that causes self-annihilation (Glasenapp 1942/1915, 17; Wiley 2000a, 171–72).[5] Apart from playing a significant role in bringing about fatal injury, this karma is an important factor in the production of illnesses arising from the three humors (*tri-doṣa*) of wind (*vāta*), bile (*pitta*), and phlegm (*śleṣman/kapha*).[6] Drawing from Vīrasena's *Dhavalā* (ninth century), Wiley notes that without this specific kind of karma there would be no affliction arising from the three humors (2000a, 270).

Mari Jyväsjärvi Stuart points out that the presence of the doctrine of the three humors in Jain texts indicates that Jain authors were familiar with traditional Indian āyurvedic medicine, which posits a foundational theory of three humors whose imbalance causes illness (2014). In his commentary to the *Tattvārtha-sūtra*, J.L. Jaini lists wind, bile, and phlegm as secondary constituents of the body (*upadhātu*), along with tubular vessels (*śirā*), muscle (*snāyu*), skin (*carma*), and digestive fire of the stomach/gastric fluid (*udara-agni*); the primary constituents of the body (*dhātu*) include chyle (*rasa*),[7] blood (*rakta*), flesh (*māṃsa*), fat (*meda*), bone (*asthi*), marrow (*majjā*), and semen (*śukra*).[8] Two types of *nāma-karman* cause the proper and improper functioning and circulation of the primary and secondary bodily constituents, namely *sthira-nāma-karman* and *asthira-nāma-karman*, respectively (Jaini 1920, 168–69; see also Wiley 2000a, 170). As a cause of the imbalanced circulation of wind, bile, and phlegm, along with other bodily dysfunctions, *asthira-nāma-karman* can, then, also be understood as a factor that contributes to the arising of illnesses.

Asthira-nāma-karman weakens the body and exposes it to ailments in other ways as well. In his commentary to the *Tattvārtha-sūtra*, Akalaṅka follows his predecessor Pūjyapāda in stating that while *sthira-nāma-karman* causes a firm bodily constitution, which enables one to undergo austere ascetic practices without falling weak and ill, *asthira-nāma-karman* in combination with even the lightest austerities results in an exhausted body:

> From the rise of this [*sthira nāma*] *karma*, upon performing austerities such as severe fasts, etc., the limbs and minor limbs remain unchanged, in other words, the body remains robust and in good health. It does not become emaciated or weak. *Asthira nāma karma* causes unsteadiness and weakness and emaciation of the body from undertaking only one fast or from exposure to ordinary cold and heat. (TVā 8.11.34–35, trans. Wiley 2000a, 170)

Akalaṅka highlights that a person with a weak bodily constitution is not only prone to illness but also cannot perform rigorous austerities that Jain texts prescribe for mendicants, suggesting that a healthy body is necessary on the path of karmic purification, which we will return to later in this chapter.

Ugrāditya (c. ninth century) mentions blood as a cause of disease in addition to the three humors (KK 15.255–273),[9] but he sometimes also lists it as a humor (KK 3.67), or as something that can get corrupted by the humors (KK 9.15; KK 9.35)[10]

(Meulenbeld 2000, vol. IIA, 152; Meulenbeld 2000, vol. IIB, 175). As a primary bodily constituent, blood is also regulated by *sthira-nāma-karman* and *asthira-nāma-karman*, much like the three humors.[11]

The idea that ailments can be a result of bodily disturbances—specifically, the imbalances of the three humors of wind, bile, and phlegm—can be found already in the *Bhagavatī-sūtra* and the *Sthānāṅga-sūtra*. Each illness is named in accordance with the imbalance that causes it, be it wind (*vātika*), bile (*paittika*), phlegm (*śleṣmika*), or a combined imbalance of the three (*sānnipātika*) (BhS 18.10§758a; SthS 4.4.515).[12] Texts indicate that these imbalances can be caused by external factors. For example, the *Bhagavatī-sūtra* recounts a story of a mendicant called Jamālī who had been consuming improper foods (tasteless, leftover, too meager, dry, untimely, excessive, and so on) and consequently suffered from bilious fever (*pitta-jvara*), running a high temperature (BhS 9.33§484a).[13] J.C. Sikdar explains that in Jamālī's case "the normal function of the physical system was disturbed by the generation of more heat from the bile on account of unsuitable and untimely diet" (1964, 348). In accordance with this, Ugrāditya in his *Kalyāṇa-kāraka* pays great attention to the kinds of foods that should be consumed. However, it was not only food that was considered as being able to influence the condition of the humors. Apart from other changes in one's lifestyle, such as walking when one's humoral imbalance has been caused by excessive sitting (for more on lifestyle choices and illness, see below), Stuart also mentions the provision of massages, resting on or wrapping oneself in animal skins, and specific bed arrangements (2014, 78–79) as methods of treating illnesses arising from the humors. Sen, further, lists various treatments with powders and oils aimed at restoring the balance of the humors (1975, 185; see also Stuart 2014, 79).

The *Bhagavatī-sūtra* contains an account of an encounter between Mahāvīra and Makkhali Gosāla, where bilious fever is stated to be a result of a hot ray emanated from a powerful ascetic. Makhali Gosāla was the leader of the Ājīvikas, but according to the Śvetāmbaras, he was for six years also a student of Mahāvīra before the latter's attainment of omniscience. During this time, Mahāvīra taught Gosāla the power of emitting fiery heat (see chapter 2, note 57) after a particularly dangerous encounter with another ascetic. Their relationship, however, came to an end, when Gosāla left his teacher and proclaimed himself a Jina. Sixteen years later, when Mahāvīra had already attained omniscience, Gosāla tried using his yogic power of emitting heat on Mahāvīra himself in order to kill him, announcing that Mahāvīra would die of a bilious fever in the course of six months. The fiery ray, however, rebounded from Mahāvīra, striking Gosāla instead. Gosāla became delirious and died soon after the event as a consequence (BhS 15.C7§677b, 15.C9§682a). The *Bhagavatī-sūtra* states that Mahāvīra himself also got bilious fever soon after the attack, and the topic of how he recovered from it is quite controversial. The text states that he consumed meat of a cockerel that was killed by a cat and therafter regained his strength (BhS 15.C11§685b),[14] but commentators have offered alternative interpretations that are in accordance with the strict rules

of the meatless Jain diet.[15] In any case, the narrative suggests that bilious fever was a direct result of overheating the body due to an external factor, similar to the case of Jamālī.

Jain texts—particularly medieval didactic stories and narrative literature—sometimes, further, assign illnesses to various divine and human curses. Especially prominent are narratives about leprosy as a result of malicious curses. Phyllis Granoff recounts a story of King Kumārapāla:

> The famous Jain king Kumārapāla is said to have suffered from leprosy . . . caused . . . by the curse of a goddess who felt slighted. He is cured by water consecrated by his preceptor, the Jain monk Hemacandra. This same Hemacandra is similarly said to have suffered from leprosy as the result of an ancient curse and to have cured himself through meditation. (1998a, 220; see also 230–34)

It seems that Jain religious rituals (recitations of hymns; use of consecrated water; meditation; worship of Jina images, deities, and texts; and so on) and contact with spiritually accomplished mendicants (through their bodily parts and bodily residue)[16] are particularly helpful in treating physical illnesses that are caused by malevolent deities and ascetics (224–25), where conventional medicines can perhaps be less effective.[17] However, religious healing is also used for illnesses caused by other factors, such as bodily imbalances (219, 239–41).[18]

More generally, Jain texts describe illness as being induced by certain lifestyles and behaviors, which include dietary choices and modes of eating. *Sthānāṅga-sūtra* lists nine reasons (*sthāna*) for illness: (1) sitting for prolonged periods or overeating (*atyāsana*), (2) sitting in a "harmful" posture or eating "harmful" foods (*ahita-aśana*),[19] (3) too much sleep (*atinidra*), (4) too little sleep or staying awake too long (*atijāgarana*), (5) restraining the urge to pass stool (*ucchāra-nirodha*), (6) restraining the urge to pass urine (*prasravaṇa-nirodha*), (7) excessive walking (*adhvagamana*), (8) unsuitable meals (*bhojana-pratikulata*), and (9) excessive sensuous pleasures (*indriyārtha-vikopana*)[20] (SthS 9.13). While the text provides only the list of reasons without any further explanation, N.L. Jain suggests that they result in the four kinds of disturbances of the humors mentioned above, which is aligned with the recommendation of walking and proper bed arrangements as ways of balancing the humors, discussed earlier (1996, 533).[21] Stuart notes that lists such as this one indicate that Jains were interested in etiology and possibly in preventing illness (2014, 71). Controlling the mind and body, she states, might deter illnesses or diminish the possibility of their occurrence (68). "The regime of moderation and simplicity that Jain mendicants are expected to follow," she writes, "represents the polar opposite of these deleterious habits. It is not unimaginable that this list may have provided a basis for a rudimentary conception of health maintenance among Jain mendicants" (71).[22]

Finally, a decline in bodily power (*bala-prāṇa*) and old age are also associated with physical illness (US 10.21–27). As explained in chapter 2, the age of fifty initiates the start of a gradual decline in a person's strength, which may lead to illness.

It is interesting to note that while some of the causes of illness that were discussed seem to be interrelated, certain texts strictly differentiate between them. Granoff points out that the story of Vimala in Maheśvarasūri's *Jñānapañcamī-kathā* (Pkt. *Nāṇapaṃcamī-kahāo*) emphasizes that illnesses arising from bad food or bad digestion can be treated, whereas those that arise due to karma cannot and can only be terminated upon death (1998a, 235). This differentiation suggests a fundamental distinction between illnesses generated by karmic causes and those stemming from more general lifestyle choices. The idea of karmically induced illnesses being resitant to cures seems to be based on the belief that every living being needs to work through the karma they have accumulated due to their own previous deeds (see chapter 2). Granoff observes that texts allow for exceptions, and she recounts a story of a young girl whose illness, which was caused by karma, is cured with a religious ritual (1998a, 234). However, she adds, some texts point out that even if illnesses resulting from karma are cured in the present, they will manifest again in the future until they are fully experienced (246–47). One's own past activities are, thus, understood as a deeper cause of the present ailments.[23] Granoff indicates that karmically caused illnesses can be properly healed only through the performance of austerities, which bring about the destruction of inauspicious karma (220, 248). This way, the cure for physical illness is also the means of progress on the religious path (249–50).

To summarize, physical illness afflicts the gross physical body of living beings that inhabit the "lands of action." Illness is described as being caused in several different ways, including karma associated with pain or unpleasant experiences, karma causing disfigurement or self-destruction, and karma causing a weak bodily constitution as well as improper functioning and circulation of the primary and secondary bodily constituents. Some of these are noted as being related to the imbalances in the bodily humors as causes of ailments. Other external instruments that can cause illness and are sometimes directly mentioned as being related to the imbalances in the bodily humors are unhealthy lifestyle habits and even malicious ascetic powers. Various curses are also described as triggering illnesses. A more general factor in bringing about illnesses is the decline in vitality due to old age. It is indicated, moreover, that a weak body and illness can hinder one's ascetic practice.

Jain texts do not seem to clearly explain how all of these different causes of illness are related. There are some indications of interrelation between them, but there are also passages that suggest certain fundamental differences among them. Karmically induced illnesses are specifically highlighted as those that are most difficult or even impossible to heal, with one's past activities being understood as the root cause of afflictions. The conventional types of medical treatment for physical illness that were mentioned in this section include changes in lifestyle choices, provision of massages, and treatments with powders and oils. Further kinds of conventional medical treatment will be mentioned in the later parts of

this chapter. The unconventional types of medical treatment that were described are various types of religious healing. It was indicated that the most successful form of medical treatment is austerities, which eliminate inauspicious karmas.

Mental Illness

As with physical ailments, Stuart describes the imbalance of the humors as one cause of mental illness, which can be treated by providing food suitable to that condition (2014, 90). In the above-mentioned passage from the *Sthānāṅga-sūtra* that lists various lifestyles that can lead to the arising of illnesses, the commentator Abhayadevasūri interprets the last reason of excessive sensuous pleasures (*indriyārtha-vikopana*) as a cause of potentially fatal mental illness. He glosses it as "sexual excess" (*kāma-vikāra*), "for mental illness (*unmāda-roga*) arises because of affection for women, etc.; as it is said: first there may be affection, then pensiveness, then recollection, then praise of qualities, admiration, raving, mental illness [*unmāda*], then [physical] illness [*vyādhi*], apathy, and, finally, death" (trans. Bollée 2003–2004, 162, fn. 10, modified). As noted above, some have interpreted these lifestyle choices as disturbing the balance of the humors, which then leads to illness.

Many texts, however, seem to classify mental illnesses (*unmāda*) under a distinct category, reflected in their attribution to different causes from those that generate physical illness. The *Bhagavatī-sūtra*, for instance, lists two causes of mental illness: (1) being possessed by a demon (*yakṣa-āveśa*) and (2) the rising of deluding karma (*mohanīya-karman*). Similarly to physical illnesses, where karmically caused types are described as being resistant to cures, the text asserts that "it is easier to bear and get rid of the first kind [i.e., possession]. . . .[24] Beings contract the first kind when (they ingest) impure particles . . . (which) are sent off by a god (*deva*)" (BhS 14.2§634a, Deleu 1996/1970, 204).[25] The *Bṛhatkalpa-bhāṣya* explains that in the case of mental illness caused by deluding karma, "the inauspicious matter arises in one's own body.[26] In case of beings possessed by a *yakṣa*, it is necessarily coming from outside one's body" (BBh 6256; trans. Stuart 2014, 88).[27] Sikdar comments on these two kinds of mental illness: "The *Yakśāveśa*-insanity [*sic*] brings the state of happiness (*sukhavedanataraka*) and its cure is accompanied by happiness, while the *Mohanīyakarma*-insanity is full of suffering (*duḥkhavedanataraka*) and the cure or release from it is attained with pain (*duḥkhavimocanataraka*)" (Sikdar 1964, 349).

In his list of diseases in the canon, Jain mentions the following diseases that he describes as "demonal": *indra-graha, skanda-graha, kumāra-graha, bhūta-graha, yakṣa-graha*, and *nāga-graha* (1996, 536).[28] The word *graha* indicates that a person is "seized," and Bollée translates it as "possession" (2003–2004, 176). He interprets *indra-graha* and *skanda-graha* as astral possessions, and *bhūta-graha* as possession by a *bhūta* (malignant demon). Bollée additionally mentions possession by a *piśāca*, another demonic type of being (179).

An example of a mental illness caused by *yakṣa-graha* is described in the *Antakṛd-daśāḥ* (Pkt. *Aṃtagaḍa-dasāo*).[29] In this story, a garland-maker named Ajjuṇae gets possessed by a *yakṣa* called Moggarapāṇī whom he had worshipped as a protective deity. One day, as his wife Bandhumaī and he started their worship, a group of attackers tied him up and sexually assaulted Bandhumaī. Witnessing the violence, Ajjuṇae started to doubt the existence of the protective deity he had been worshipping, and as a response the *yakṣa* entered his body.

Possessed by the *yakṣa*, Ajjuṇae killed the attackers and his wife, and went on killing for days until he encountered a deeply religious Jain merchant, Sudaṃsaṇe, on his way to pay respects to a Jain ascetic who had just come to town. As Ajjuṇae advanced to attack and kill him, Sudaṃsaṇe stayed fearless and undisturbed. He raised his hands with joined palms, paid homage to the Jinas and the ascetic, and took the five great vows. Consequently, because of the power he attained, Ajjuṇae could not reach him, and so he stopped before Sudaṃsaṇe and stared at him for a long time. Finally, the *yakṣa* exited the body of Ajjuṇae and went away. Ajjuṇae himself went on to become a Jain monk and eventually attained liberation (AD 6.3).[30]

Perhaps the calm demeanor of Sudaṃsaṇe could be interpreted as the state of happiness that cures the *yakṣa*-induced type of mental illness, mentioned by Sikdar above. The emphasis on Sudaṃsaṇe's religiosity, however, seems to locate the healing power in the Jain religion itself (Aukland 2013, 117). Accordingly, Stuart states that mental illness caused by possession can be treated by mantras and similar esoteric techniques that overpower the *yakṣa* (see also Wiley 2000a, 268). This is in line with the previous section, where religious healing was found to be commonly used for treating physical ailments caused by ill-intentioned deities and ascetics.

Stuart explains that mental illness caused by deluding karma, on the other hand, is "essentially caused by weakness of one's mind and moral integrity, so that one gives into negative emotional states such as fear, passion, or arrogance" (2014, 88). One can become mentally unstable as a result of experiencing great fear or passion, not being treated well, or even being treated with excessive praise. Consequently, one might become overly fearful, arrogant, and so on, which points to an interesting link between emotions and karmically caused kinds of mental illness. Along with the four main passions (*kaṣāya*), emotions or subsidiary passions (*no-kaṣāya*) are considered products of conduct-deluding karma (Jaini 2001/1979, 118–21). Umāsvāti lists nine of them: laughter (*hāsya*), pleasure in sense activity (*rati*), displeasure in sense activity (*arati*), sorrow (*śoka*), fear (*bhaya*), disgust (*jugupsā*), and sexual desire or feeling toward women, men, and both women and men (*strī-puṃ-napuṃsaka-veda*) (TS^{Dig} 8.9).[31] Based on the sources we have explored, it is unclear whether the difference between an excessive emotion and karmically induced mental illness is merely a matter of degree or whether there is a qualitative difference between the two. The case of sensuous pleasures mentioned above—which is not explicitly described as being tied to deluding karma—seems

to identify excessive emotion as a *cause* of mental illness (see also Stuart 2014, 89). The sequence from admiration to raving and eventually mental illness indicates intensification of the same emotion, as does the case of extreme fearfulness, for example, as stemming from the experience of great fear. However, in the sequence, mental illness is followed by the effects of physical illness, apathy, and death, which indicates that the items on the list may also differ qualitatively.

This type of mental illness, Stuart states, can be treated in two ways: (1) a gentle approach that aims to induce the opposite emotions to the one that the patient is undergoing, and (2) an approach that she likens to a sort of shock therapy (88). The gentler approach might try to counter excessive fear by evoking reassurance in a person or humbling an excessively arrogant person, following a prior attempt to alleviate the patient's illness with religious instruction (89, 91). The latter approach might include bringing a tame lion to a patient who is afraid of them in order to pacify their fear. In the worst-case scenario, a mentally ill patient may be restrained in isolation by being tied up in a closed room or thrown into a well (92–93). "Such a shock therapy approach," notes Stuart, "is based on the assumption that the imbalanced state of mind is a temporary condition, and that the patient can be shaken out of it by having her undergo a shocking or otherwise powerful experience" (2014, 91).

However, drawing parallels with physical illnesses that result from karma, none of the conventional treatments for mental illnesses are able to reach the underlying cause of these ailments. At the karmic level, then, mental illnesses that result from deluding karma can be cured "by the destruction-cum-suppression (*kṣayopaśama*) of this *karma*" (Wiley 2002a, 268).

In the context of mental illnesses, Jain texts also open up a question of agency. Is a person who is mentally ill responsible for their actions? Colette Caillat cites postcanonical mendicant texts stating that a mendicant is not responsible for actions done while mentally ill, for such a person lacks freedom.

> The teacher affirms that if a religious is, for example, suffering from a mental illness, his [*sic*] conduct is predetermined. He does not accumulate any *karman* and has therefore nothing to expiate. . . . To illustrate his arguments, the teacher gives the example of the marionette whose many actions are in fact caused by someone else and bring it no benefit. (1975, 110; see also Deo 1954–55, 437)[32]

Although an individual suffering from mental illness may not be karmically responsible for their actions, such behavior does impact the immediate mendicant community, requiring some response. Caillat cites instructions for fellow mendicants to guard a mentally distressed mendicant closely, since they would be responsible for any injurious actions committed by that mendicant, and to use extreme care when seeking food or other articles of care for their treatment (110).

In sum, whereas some textual passages attribute mental illnesses to bodily imbalances that can be treated with changed lifestyle choices, they are usually

categorized differently from physical illnesses. As we saw, they are caused by a different kind of karma or may even be brought about by an external force entering the body. As such, they sometimes also seem to require healing approaches that differ from those used for treating physical diseases. However, just as in the case of physical illnesses, religious healing may be used for mental illnesses induced by malevolent beings, and ascetic practices are highlighted as a way to eliminate the underlying cause of mental illnesses that result from karma. Mental illnesses, furthermore, open up discussions about human agency, responsibility, and karmic retribution.

MENDICANTS AND MEDICAL TREATMENT IN THE EARLY ŚVETĀMBARA CANON

One central issue in the field of Jain medicine is whether mendicants can give and receive medical treatment. Does illness weaken or strengthen mendicant practice? Is it another physical hardship to be endured, just like extreme cold and scorching heat, or can/should it be treated? If the latter, who can provide treatment and what kinds of medicines may they use? Does a healthy body have a function in Jain mendicancy? The issue of the medical treatment of mendicants is significant because it raises ethical questions about proper conduct in the face of illness that are unique to Jain history and practice, establishing foundational guidance for other topics that relate to medicine. These considerations involve two parties: the ailing mendicant and the care provider. In this section we will discuss both perspectives.

As indicated in chapter 3, the practices of Jain mendicants today often do not entirely align with those described in the early textual sources, even though these sources—for Śvetāmbaras at least—are generally considered authoritative and are believed to contain the original teachings of the last Jina, Mahāvīra. This holds also in the case of medical treatment. For example, while the early texts encourage a mendicant to endure all pain—including illness—with calm and without seeking aid, some monks and nuns today consent to receiving medical care, ranging from plant-based curatives to full-scale surgery, as we will further explore in chapter 6. What explains this shift and when did it happen?

In his analysis of medicine in Buddhist monasticism, Kenneth Zysk states that "medicine generally played an insignificant role in Jaina monasticism" (1991, 8). He points out that mendicants clearly had knowledge of illness and medical treatments, but "because of the severity of their ascetic discipline, the cultivation and practice of techniques to remove and ease suffering operated essentially as a hindrance to spiritual progress. Hence Jainas did not codify medicine in their monastic tradition" (38; see also Stuart 2014, 64).

Some scholars have challenged the notion of a strict prohibition of medical treatment in Jain mendicant texts. While they have recognized mostly negative

approaches to the medical treatment of mendicants in the early Jain canon, due to the strict adherence to performing austerities while accepting pain, discomfort, and illness, they have also highlighted a later shift to more lenient attitudes. Granoff mentions the canonical example of Mahāvīra taking medicine in the *Bhagavatī-sūtra* discussed above, but she, similarly to S.B. Deo and Stuart, locates a greater acceptance of medicine in the medieval texts (Granoff 1998a, 222, 254; Deo 1954–55, 29–33; Stuart 2014, 65–67).[33] We will return to these analyses later in the chapter.

Based on her study of the approaches to medicine in the Śvetāmbara canon, Stuart notes:

> On the basis of the canonical texts alone . . . it is not possible to conclusively determine to what degree early Jain mendicant communities resorted to the medical treatments of which they were clearly aware. However, the fact that exceptions to monastic rules for the sick are recorded even in these early texts suggests that Mahāvīra's example of perfect tolerance of discomfort very quickly turned out to be a difficult one for his followers to emulate. (2014, 72)

In line with this, we argue that the rare accommodations for ill mendicants that are permitted in the early canon in specific circumstances may have contributed—together with the emerging duty to care for the sick and the idea of a healthy body as the vital instrument of spiritual attainment—to the development of more lenient attitudes toward the medical treatment of mendicants later on. This means that the historical gap between the early and the later sources with regard to the care directed toward ill mendicants may not have been all that great.

In the next section, we explore the evolution of attitudes toward medicine in what are commonly understood to be four of the earliest canonical sources: *Ācārāṅga-sūtra* I, *Sūtrakṛtāṅga-sūtra* I,[34] *Uttarādhyayana-sūtra*, and *Daśavaikālika-sūtra*.

Medicine as Violence and the Illness of Saṃsāra

As discussed in chapter 3, the *Ācārāṅga-sūtra* I is a manual of conduct that encourages individuals to cut off familial and community ties in order to pursue a path of strict mendicant practices that erode karma, ultimately freeing one from the cycle of rebirths. As a text that promotes the ideal of solitary mendicancy, the *Ācārāṅga-sūtra* I mainly provides guidance for individual mendicants who face illness, and only briefly discusses proper interactions when a mendicant falls ill. The text describes the body as something transitory and impure, to be overcome, even while that very body is the instrument with which one performs religious austerities. Since liberation is described as the only worthwhile aim, any activity that impedes liberation—which includes taking medication that causes harm to other life-forms and increases bodily attachment—should be avoided. Likewise, householders or doctors who provide harm-causing treatment are also denounced. At the same time, the text admits that the rigors of mendicant life require health and

strength, and encourages individuals to take up austerities while their bodies are still able to perform them. We will discuss each of these unique features in turn.

The notion of karma in this text is not as extensively defined and theorized as it will be in later texts (see chapter 3). The view, simply stated, is that the varieties of embodied experience of living beings arise from karma (ĀS 1.3.1.4), including their birth state, bodily condition, and occurrences of illness (on which more shortly). Since one's karma is determined by actions, the text emphasizes that everyone is responsible for their own rebirths, meaning that the agent of an action not only reaps the fruit of that action, but is also the only one who can prevent the accrual of new karma. Mendicants manage their karma-causing actions in several ways, primarily by controlling their attachments (*parigraha*) and minimizing actions that cause harm (*ārambha*). As described in chapter 3, harm-causing activities can be performed directly, or one can cause or approve of another doing them.

One way in which wandering mendicants are instructed to observe these guidelines is by collecting alms from householders rather than preparing or purchasing their own food, all the while being extremely vigilant so as not to become attached to their donors. Mendicants are, further, encouraged to rigorously expose themselves to various bodily discomforts (ĀS 1.2.6.3). The causes of discomfort may be involuntary, such as calmly withstanding severe weather conditions and the mockery of householders, or voluntary, such as undergoing austerities like assuming an uncomfortable position for a long time or fasting. As described in the text, "Enduring cold and heat (*śitoṣṇa-saha*), pain and pleasure (*arati-rati-saha*), the unbound (*nirgrantha*) does not feel the hardship (*paruṣatā*)" (ĀS 1.3.1.2).

These strict practices are based on a sharp dualism between the *jīva* and the body, with the body being described as something that should be abandoned as ephemeral and impure (ĀS 1.2.5.5). However, even though mendicants are encouraged to transcend their bodies, it is precisely their bodies that function as instruments for the performance of austerities required for the liberation of the living self. After serving as a vehicle to liberation, upon reaching liberation, the body-as-instrument is discarded (ĀS 1.5.6.4). As noted in chapter 3, the *Ācārāṅga-sūtra* I presents liberation as a goal that is immediately attainable and the only worthwhile aim of spiritual practice.

The uncompromising approach to austerities and liberation is reflected in the attitude toward medicine evident in the text. The text lists sixteen illnesses or bodily conditions understood to be a result of one's own actions:[35]

> Now, look at those born in various kinds of families as a result of their own actions! [They undergo the ailments of] having goitre/boils (*gaṇḍin*) or leprosy (*kuṣṭhin*), consumption (*rājayakṣmin*), epilepsy (*apasmārika*), one-eyedness (*kāṇaka*) and stiffness/paralysis (*jāḍya*), lameness (*kuṇitva*) and hunch-backedness (*kubjita*) also. Having dropsy (*udarin*), look, and dumbness (*mūka*), inflammation/swelling (*śūnika*), excessive appetite/over-digestion (*grāsin*), trembling (*vepakin*) and immobility (*pīṭha-sarpin*), elephantiasis (*ślīpada*), [and] diabetes (*madhu-mehanin*). These sixteen illnesses have been enumerated in due order. (ĀS 1.6.1.3)

Seeking medicine for any of these conditions is discouraged in the text, since any curative would result in harm to other beings used in the treatment itself, and all just for the sake of maintaining one's frail body (ĀS 1.6.1.4):

> Knowing [that they are attacked by] diseases (*roga*) of various sorts, the afflicted ones (*ātura*) torment [other beings for the sake of treatment]. But mind you! [All these treatments] are not [competent] enough [to remedy the afflictions caused by karma]. Refrain from these [therapeutic measures that torment other living beings]. . . . One should not harm anything [even for the sake of treatment]. (ĀS 1.6.1.4)

The prohibition against harm means that not only animal-, but also plant-, earth-, water-, air-, and fire-based medical treatments are unacceptable, no matter what the medical condition. Moreover, it is indicated that such treatments would ultimately be ineffective. Illnesses are, after all, the result of one's own actions and, therefore, karma (as discussed above). The real illness that needs to be overcome through austerities, according to the *Ācārāṅga-sūtra* I, is thus not any one bodily condition, but *saṃsāra* itself.

In spite of the general aim toward liberation rather than curing bodily conditions brought on by karma, the *Ācārāṅga-sūtra* I invites mendicants to enter a mendicant path while still in good health, before falling ill. The text states that so long as hearing, sight, smell, taste, and touch remain strong, one should pursue liberation: "Seeing that strength (*vayas*) has not yet declined, wise man, recognize the moment!" (ĀS 1.2.1.5). Although this idea is not further developed in this text, the underlying suggestion seems to be that a strong body is necessary for performing austerities.

In addition to describing the medical conditions and treatment guidelines for an ailing mendicant, the *Ācārāṅga-sūtra* I addresses those who might provide care for the sick; the text primarily discusses householders as potential caregivers. In keeping with the negative picture of householders presented in this text, one scenario describes family members who abandon a sick person. Here, the *Ācārāṅga-sūtra* I emphasizes that family, just like medicine, cannot save and protect one from illnesses (that are karmically induced) (ĀS 1.2.1.4).

Doctors are also denounced in the text as those whom a mendicant should avoid. Not only do doctors blindly perform violent actions, their patients are also implicated in the violence:

> Proclaiming himself to be an expert in medicine (*cikitsā-paṇḍita*), [a doctor] kills, cuts, pierces, breaks, tears to pieces, and destroys [life] [for the purpose of medical care]. Thinking "I will do what has not been done yet," [he continues indulging in violence]. The one whom he treats is also [involved in the violence]. Enough of the company of this unwise person! Whoever receives [such a cure] is also unwise. This is not suitable for a houseless [mendicant]. (ĀS 1.2.5.6)

Commenting on this passage, Stuart notes that "early Indian medical prescriptions often included meat, honey and alcohol, substances whose production or extraction inevitably involved harming life-forms. . . . [T]he Āyurvedic use of

these prohibited 'violent' ingredients likely contributed to their [i.e., the Jains'] misgivings about medicine" (2014, 70).

While assistance from laity is precluded, the *Ācārāṅga-sūtra* I does permit mendicants to help their sick fellow mendicants under very limited conditions. A passage toward the end of the text notes that in case of frailty, a mendicant should not accept food from a householder but may accept services of fellow mendicants when sick, should they offer it without being asked. Similarly, one may offer services to others when they are ill. However, these actions should be performed only if a mendicant had previously resolved to act in these specific ways. The rules of interaction regarding illness are thus established particularly with reference to the strict observance of one's own individual ascetic restraints and are not patient-oriented or framed as a duty to care for sick fellow mendicants. If one's prior resolution is not to accept or provide assistance in any situation, this decision should be upheld even in case of illness (ĀS 1.7.5.2–4).

When mendicants become so weak, due to factors such as disease, that they can no longer maintain their vows or austerities, the *Ācārāṅga-sūtra* I states that they may undertake a fast unto death (ĀS 1.7.5.1–1.7.8.25). This religious practice is described in more detail in chapter 7.

As a text for wandering mendicants, the *Ācārāṅga-sūtra* I details the ideal conduct required for liberation. In this context, medicine, as well as those who might provide it, not only results in violence to other living beings and damaging attachments to the body, but is ultimately considered ineffective in curing ailments brought about by karma. The text provides an option to accept and offer services in case of illness, but only if one's previous resolutions allow it. A religious solution that is presented as an option to deal with weakness and illness is the practice of fasting unto death. At the same time, the text encourages people to enter the spiritual path while their strength has not yet left them.

The Emerging Duty to Care

Similarly to the *Ācārāṅga-sūtra* I, the *Sūtrakṛtāṅga-sūtra* I encourages mendicants to abandon the needs of the body. However, this goal is balanced by a growing duty to care for mendicants who have fallen ill. In the text, mendicants are instructed to endure every involuntary pain and, at the same time, voluntarily pursue austerities. The text suggests that one should view one's body as a corpse (SKS 1.13.17), though it warns against longing for death, which was probably an important caveat for novice mendicants: "A person who has left the householding life, free from desires (*niravakāṃkṣin*), should abandon his body. . . . He should desire neither life nor death" (SKS 1.10.24).

Like the *Ācārāṅga-sūtra* I, the *Sūtrakṛtāṅga-sūtra* I discusses situations in which fellow mendicants fall ill; however, unlike the former, it establishes a *duty* to care for them. In one passage, the text describes mendicants collecting alms-food for

their sick brethren whose illness made them exempt from seeking their own alms. Although this practice is criticized by rival groups, the text defends mendicants seeking alms for a sick monk as much more preferable than a householder bringing food to the ailing mendicant. This preference, which was indicated already in the *Ācārāṅga-sūtra* I, seems to reflect a belief that mendicants should never accept food that householders prepared especially for them. Even though the passage demonstrates an awareness that such behavior might be seen as reflecting relationships of attachment, it nevertheless concludes that "a healthy mendicant should, steadfast, help a sick one" (SKS 1.3.3.8–11, 15, 20). This excerpt does not discuss medical treatment, yet it importantly establishes—perhaps for the first time—the *duty*, rather than merely an option, to provide care for a sick fellow mendicant. It also suggests, without reference to any previous individual resolutions like in the *Ācārāṅga-sūtra* I, that mendicants who have fallen ill are exempt from performing certain obligatory activities, such as collecting alms.

The duty to provide care opens space for a wide variety of interpretations of what exactly "care" consists of. Moreover, it is precisely within the domain of the duty to provide care for fellow mendicants that the lenient attitudes toward the medical treatment of mendicants in the postcanonical period, described by Granoff and Stuart, flourished.

Why did a duty to care emerge in the *Sūtrakṛtaṅga-sūtra* I? Taking care of sick fellow mendicants seems to be one aspect of a broader restructuring of the rules of proper conduct and its rewards in the text, which could be interpreted as reflecting the growth/stabilization of the Jain mendicant community, as well as a concern for its unity. As noted in chapter 3, the text recognizes that some mendicants may be too weak to emulate the solitary and rigorous lifestyle of Mahāvīra. It also encourages students to stay with and serve their teachers, another way in which service is underlined as important. Along with this, the text records the emergence of the idea of a good rebirth as a worthy goal of practice. Any or a combination of these developments could perhaps be the reason behind the (at least seemingly) novel idea that fellow mendicants are obliged to provide care to sick mendicants, who may be exempt from performing certain religious obligations.

The Body as an Instrument of Liberation

The contents of the *Uttarādhyayana-sūtra* reflect the general avoidance of medicine found in the previous texts, while recognizing the body as a vital instrument for the performance of karma-destroying austerities. Aligned with the *Ācārāṅga-sūtra* I and the *Sūtrakṛtāṅga-sūtra* I, the *Uttarādhyayana-sūtra* urges mendicants to cultivate indifference to pleasant and unpleasant experiences toward the ultimate goal of leaving the impure body behind. Accordingly, a mendicant who falls ill "should not wish for medical treatment (*cikitsā*), but continue to explore the self. Thus, he will be a proper mendicant by neither acting himself nor causing

others to act" (US 2.33). This view reflects the threefold notion of action described in chapter 3, namely that mendicants should not wish for medical treatment themselves, but also not cause others to provide care.[36]

The *Uttarādhyayana-sūtra*, further, discourages mendicants from lamenting their fellow mendicants' condition or participating in their medical treatment. The text cautions: "*Mantra*s, roots, various kinds of medical consideration (*vaidya-cintā*), emetics, purgatives, fumigation, eye [treatment], and bathing, [sharing in] the sick one's lamentation and his medical treatment, one who, understanding, renounces these is a [true] mendicant" (US 15.8). As in the previous texts, rather than paying attention to bodily illness, the ultimate goal of a "true mendicant" is to overcome the disease of *saṃsāra*. With this attainment, "one becomes free from all suffering that always afflicts humankind. Freed from the long illness (*dīrgha-āmaya*) and praiseworthy, he becomes infinitely happy, obtaining the [final] goal" (US 32.110). Similarly to the *Ācārāṅga-sūtra* I, the *Uttarādhyayana-sūtra* also presents the option of fasting unto death as one's end nears (US 5.32).

At the same time, the *Uttarādhyayana-sūtra* opens a space to consider a particular value of medical treatment, namely maintaining the body for the practice of austerities. While the idea that the body is a tool of spiritual progress is largely implicit in the other early canonical texts discussed in this section, the *Uttarādhyayana-sūtra* unambiguously explains that one should sustain one's body only in order to destroy previously accumulated karma (US 6.12). This perspective presents the body as a vital instrument for attaining spiritual goals, and, similarly to the *Ācārāṅga-sūtra* I, the text explicitly identifies illness (*roga*) as one of the factors that renders rigorous disciplines difficult (US 11.3). This is one avenue by which space opens up for a reconsideration of medical treatment as a means to sustain a healthy body capable of performing karma-destroying austerities to the extent that they are prescribed and, consequently, effective.

Moderate Accommodations for the Sick

While instructing mendicants to bear bodily hardships, the *Daśavaikālika-sūtra* also demonstrates a clear concern for the sick and a developed duty to care for fellow mendicants. Like the previous texts, the *Daśavaikālika-sūtra* maintains the uncompromising ideal of a true mendicant who "is unperturbed in the face of hunger, thirst, and lying on uncomfortable ground, cold and heat, distress and fear, [for bearing the] suffering of the body [brings] great results" (DVS 8.27). The text continues: "A mendicant who is standing firm in the eternal good, should forever abandon the impure and impermanent body. Having cut off the bondage of birth and death, he reaches the state from where there is no return" (DVS 10.21).

The text, further, names several transgressive activities related specifically to medical treatment, such as "rubbing [the body] and cleaning teeth . . . medical treatment . . . application of enema and purgatives, rubbing the body with unguents. . . . None of this is undertaken," it states, "by the unbound (*nirgrantha*),

the great sages, intent upon restraint, wandering like the wind" (DVS 3.3–10). This passage clarifies that any effort to clean, strengthen, and heal the body is a deviation from the religious path. In fact, even telling someone that a certain item has curative power is considered unacceptable, since a mendicant could be indirectly involved in violence should that person decide to use it. The text, thus, warns that the householder should not be told about what can be used as medicine (*bheṣaja*), since it may be something that contains life (DVS 8.50). Moreover, according to the *Daśavaikālika-sūtra*, the virtues should be observed equally "by the novices and the wise, [the healthy] and the sick, without a break and as a whole" (DVS 6.6).

Yet, amid these strict ideals, the *Daśavaikālika-sūtra* also makes accommodations for those afflicted with old age (*jarayā abhibhūta*), the sick (*vyādhita*), and those (weak after) practicing rigorous austerities (*tapasvin*); for example, individuals in these states are permitted to sit down while on an alms round, which was typically forbidden (DVS 6.60). However, even these individuals are allowed only minor transgressions. The verse immediately following discourages additional accommodations, stating that "a sick or healthy [mendicant] who wishes to bathe, transgresses proper conduct and abandons restraint" (DVS 6.60). A sick mendicant, then, can sit down while on an alms round, but something like washing would be too great a deviation from what is considered proper mendicant conduct.

Changing Approaches to Sick Mendicants

These earliest strata of canonical texts generally discourage mendicants from seeking treatment for unpleasant and painful bodily conditions, such as illnesses, as scholars have noted. They present two main objections to medical care. First, the production and consumption of medicine—whether by a mendicant or a third party—requires violence toward other life-forms. Second, seeking medical care deviates from the practice of austerities through which a mendicant cultivates nonattachment and equanimity in the face of discomfort in order to eventually transcend bodily existence. However, as shown, these texts also contain accommodations for sick mendicants and the emerging duty to care that seem to have been mostly overlooked in scholarship.

These changing aspects possibly reflect a developing interpersonal code of conduct, perhaps as a result of a stabilizing mendicant community. Certain passages explicitly seem to be a result of specific situations where the community needed to consider how to deal with old, emaciated, and sick mendicants. While the *Ācārāṅga-sūtra* I discusses medicine mainly from the perspective of the solitary ailing mendicant, it nevertheless provides an option to accept and offer mendicant services in case of illness if such actions are aligned with one's previous resolutions. The other three texts address how a mendicant should behave when a fellow mendicant falls ill in more detail, suggestive of an increasingly communal orientation. The *Uttarādhyayana-sūtra* urges the mendicant not to participate in the lament and medical treatment of sick brethren. The *Daśavaikālika-sūtra*, however,

expresses a concern for the sick, and the *Sūtrakṛtāṅga-sūtra* I develops a concept of the duty to provide care, for example, by collecting alms for them. Accordingly, these two latter texts permit minor transgressions of general rules by those who are ill, such as sitting down while on an alms round or, as indicated, being altogether exempt from going on alms rounds. In these contexts, ill mendicants seem to stay part of the community despite their illness.

As discussed in chapter 3, these early canonical strata gradually open the possibility of karmic merit and good rebirth in the heavenly realm for mendicants and householders who demonstrate proper conduct toward mendicants, and they soften the restrictions of interacting with the householders, a liberalization that will shape later medical exchanges. Still, in this early period, a mendicant remained the preferred choice as a caretaker for an ailing mendicant, over a householder.

Another important feature that emerges in these early portions of the canon is highlighting the role of the body in the attainment of liberation. The body is the tool for practicing austerities and, thereby, as some texts explicitly express, annihilating karma. In line with this, texts, further, point to the importance of a *healthy* body for the observance of rigorous asceticism, either by encouraging householders to enter the religious path while they are still healthy and strong or by indicating that illness can prevent one from performing difficult disciplines properly. There seems to be only a small step from recognizing that only those who are strong and healthy can fully observe religious practice, to promoting medical treatment for illnesses, in order to be able to get rid of as much karma as possible. As we will see later in this chapter, this is one of the directions in which the Jain approaches to the medical treatment of mendicants evolved.

LIBERALIZATION OF MEDICINE IN LATER SOURCES

Later sources from both the Śvetāmbara and Digambara sects offer an increasingly detailed account of medicine. In this section, we shift from the early canonical texts examined above (sixth/fifth to fourth centuries BCE) to later canonical texts (third century BCE to fifth century CE)[37] and texts from the postcanonical period. These periods are not discrete, and certain ideas overlap within and between texts and periods. However, this division provides a useful, if conditional, guide to view the development of attitudes toward medicine within Jain texts over time.

Following the early canonical view, and with the above-mentioned factors of change in mind, we suggest that attitudes toward medicine in the later sources develop in several ways: (1) communal, rather than solitary, life among mendicants becomes the central concern; (2) the duty to care for a sick fellow mendicant shifts from an emerging idea in the earliest layers of the canon, to regulated practices in the later canon, to an expectation to provide care, including medical treatment, against the threat of penalty, in postcanonical texts; (3) medicine shifts from a karmic burden to a karma-destroying activity; (4) monks and nuns, and even

householders, are permitted to act as medical providers; and (5) Jain mendicants compose elaborate medical treatises, contributing Jain values to the wider literary traditions of Indian medicine.

Later Canonical and Postcanonical Śvetāmbara Texts

Under later canonical texts, we include strata of the sources analyzed in the previous section that were composed at later dates, as well as other later canonical texts. In this period, Jain authors clearly display familiarity with various aspects of medical treatment and with the wider Indian tradition of medicine known as *āyurveda*, as indicated in the first part of this chapter. In the Śvetāmbara canon, the *Sthānāṅga-sūtra*, for example, notes that medicine (*cikitsā*) is arranged around four components: (1) doctor (*vaidya*), medicine (*auṣadha*), patient (*ātura*), and nurse/medical assistant (*paricāraka*) (SthS 4.516).[38] Furthermore, experts on the body (*kāya-naipuṇika*), ash-thread therapists (*bhūtikarma-naipuṇika*),[39] and doctors (*cikitsā-naipuṇika*) are listed as three out of nine kinds of experts (*naipuṇika*). The *Sthānāṅga-sūtra* also lists eight branches of *āyurveda*, including (1) treatment of children (*kumāra-bhṛtya*); (2) diagnosis and treatment of bodily diseases/internal diseases (*kāya-cikitsā*); (3) minor surgery/treatment of eye, ear, nose, and throat (*śālākya*); (4) surgery/removal of substances that entered the body (*śalya*); (5) toxicology/science of antidotes (*jāṅgulā*); (6) treatment of mental illness (*bhūta-vidyā*); (7) science of aphrodisiacs (*kṣāra-tantra*); and (8) alchemy and science of elixirs (*rasāyana*) (SthS 8.26).

Later canonical texts additionally include various lists of illnesses, similar to the one mentioned in the previous section, as well as a wide range of healing methods. The *Vipāka-śruta* (Pkt. *Vivāga-suyaṃ*),[40] for example, enumerates the following types of āyurvedic medical treatment, some of which overlap with the treatments that are described (and prohibited) in the early canon:

> Oil massages, massages using powders, oily drinks, inducing vomiting, purgatives, burning, medicated baths, enemas, head treatments, dressing, opening of veins, scraping, piercing, oil-baths for the head, oblations, medical herbs cooked in a special way, bark, roots, bulbs, leaves, flowers, fruits, seeds, bitters, pills, drugs, and medications. (VŚ 1.1.9, trans. Stuart 2014, 71–72)[41]

At the same time, later canonical texts retain an aversion toward medicine that is typical of the early canonical strata. While the *Sthānāṅga-sūtra* clearly shows an understanding of the medical discipline, as shown above, it also describes medicine (*cikitsā*) as one of the eight types of false/inauspicious learning (*pāpa-śruta*) (SthS 9.27). Along with studying medicine, undergoing medical treatment is likewise disapproved of. The *Niśītha-sūtra*,[42] for example, reproaches mendicants for even cleaning out a wound:

> Whichever monk, for the sake of beautification, cleanses or washes out a wound on his body . . . massages or rubs it . . . smears or massages it with oil, ghee, fat, or butter

> . . . wipes or rubs it with clay or grass . . . cleanses or washes it with cold or hot water . . . blows on it or paints it . . . is [guilty of] enjoying himself. (NS 15.112–17, trans. Stuart 2014, 70)

Though associated with the "beautification of the body," several items on this list refer to methods of healing that are commonly censured in canonical texts. Since it does not refer to other medical providers, this passage particularly highlights the proscription of medical self-care.

However, similarly to the earliest canonical strata, mendicants are also warned against receiving medical care from another party (70). Following the early canonical approach, receiving care from householders remains supremely suspect during the later canonical period. The later strata of the *Ācārāṅga-sūtra*, for example, warn mendicants against seeking shelter with householders because they may unintentionally get involved in improper conduct. This is a particular danger if a mendicant who stays with householders suddenly falls ill. In order to help, the text states, the householders may smear the mendicant's body with various substances, such as oil, rub it, clean it, and so on, thereby violating rules of mendicancy (ĀS 2.2.1.8; see also Stuart 2014, 74–75). In line with this, the *Jñātṛdharma-kathā* offers a cautionary tale of an ascetic called Śailaka who fell ill due to a bad diet. When he came to pay respects to Śailaka, King Maṇḍuka noticed how unwell the ascetic was and offered to help him get medical treatment as well as provide a place for him and his students to stay. The ascetic accepted the help, and the doctors (*cikitsaka*) started to treat him, prescribing him alcohol (*madyapāna*) among other therapeutic methods.[43] The treatment was effective and Śailaka recovered. However, instead of returning to his mendicant way of life, he continued drinking alcohol and eating abundantly, and, thus, strayed from the path of ascetic discipline. It was only after a time that he found his way back to religious practice. The story emphasizes the dangers of medical care and the underlying attachments that lead to the perpetuation of one's stay in the cycle of rebirths (JK 5).

Yet, even as medicine remained marginal, the duty to care for fellow mendicants for the sake of communal solidarity and stability seems to have become more central and regulated. The *Sthānāṅga-sūtra* warns that an *ācārya* who does not take care of ailing mendicants can create disputes among the community (5.48), indicating that far from being only a private matter, illness can potentially fracture mendicant groups. Taking care of sick fellow mendicants is thus not placed only in the hands of individual mendicants, but is rather highlighted as a responsibility of the community leader, whose task is to ensure that the sick receive proper support.[44] In tandem with this concern about communal conflict and unity, the later strata of the *Uttarādhyayana-sūtra* reiterate the early canonical accommodations for mendicants in certain situations and conditions. The text states that a mendicant can forgo collecting alms for six reasons, one of them being illness (US 26.34–35).

Texts from this later canonical period reveal a more candid familiarity with medicine and medical treatments. Still, even though providing care and accommodations for sick mendicants seems to be an essential part of maintaining a strong community, efforts persist to regulate such concessions within the framework of stringent mendicant rules of conduct.

In the postcanonical period, the disinclination toward providing and accepting medical treatment remains especially prominent in medieval Jain didactic stories and narrative literature, discussed by Granoff and mentioned in the first section of this chapter (1998a). This literature is characterized by a persistent ambivalence toward healing, particularly when it comes to mendicants. Advanced mendicants who have healing powers are reluctant not only to heal others, whom they occasionally do heal, but also themselves—emphasizing the importance of abandoning the body for the purpose of exiting the cycle of rebirths. Importantly, mendicants who use their powers to heal others are sometimes praised, while texts remain suspicious of those mendicants who accept treatment. In this context, agreeing to medical treatment is portrayed as a temptation of sorts by which mendicants might deviate from the strict ascetic path (244–45). If they do decide to either receive treatment or heal themselves, their resolution is usually justified by a reason other than their own well-being, such as the reputation of the Jain religion or community. One such case is the story of Abhayadevasūri, who fears that his illness might shed a wrong light on the Jain teachings, if people interpreted it as arising from his commentarial misinterpretation of the doctrine (239–41).

The mendicant manuals in the postcanonical period that we will explore next reflect much more lenient approaches to the treatment of ailing mendicants than the canonical sources and medieval stories just discussed. While considerations of treating ill mendicants continue to be a struggle, the difficulties seem to be more practical and communal than soteriological. In this regard, it is interesting to compare the different genres of Jain literature, their purpose, and the related ideals of mendicancy they expound. Juan Wu notes:

> The somewhat divergent stances on medical healing in medieval Jaina narratives and legal commentaries [i.e., mendicant manuals] might be explained in view of the different genres of the two types of sources. While legal commentaries address pragmatic concerns of mendicants and thus tend to accommodate the needs of physical care, narrative literature functions as a medium instantiating religious ideals and values, thus laying more emphasis on the ascetic commitment to tolerating bodily suffering. (2017, 328)

In examining postcanonical mendicant manuals, it is, first of all, important to point out that discussions of the treatment of ailing mendicants are no longer marginal, as they are in the canonical texts. Based on her analysis of three Śvetāmbara commentaries (*bhāṣya*) composed around the sixth to seventh centuries CE—the *Niśītha-bhāṣya*, the *Vyavahāra-bhāṣya*, and the *Bṛhatkalpa-bhāṣya*—Stuart

writes that they "reveal not only an interest in, but an urgent insistence on, practices of healing and how they might apply to Jain monks and nuns. These texts acknowledge that the ascetic body, weakened by years of arduous penances and fasts, can be subject to illness, and that this is a matter of collective concern for the monastic community" (2014, 72). A concern that was indicated in the early canonical strata through the emerging duty to care and minor nonmedical accommodations for ailing mendicants is now transformed into complex considerations of how to treat the sick and becomes one of the central preoccupations of mendicant authorities (66).

In these new contexts, the duty to provide care becomes a strict obligation. In his 1954 analysis of Jain monasticism, Deo asserts that caring for an ailing fellow mendicant is no longer optional in the postcanonical texts, but is a standard duty of all mendicants. He writes: "It was expected of every monk that he should wait upon the ill. Even if the ill belonged to his own or other gaccha [i.e., mendicant lineage], or was at a distant place, the monk had to go to him" (1954–55, 437; cf. Granoff 2017, 31–34). Granoff concurs that, in the postcanonical texts, "it is the duty of every monk to rush to the aid of sick brethren" (2017, 23; see also Stuart 2014, 75, 80), adding that the obligation to care was required even in the face of grave danger (36–37; see also Stuart 2014, 79).[45] An ideal that is celebrated in these texts is, therefore, not so much the endurance of illness and pain, but rather loyalty and service of mendicants or community leaders to the sick.

Beyond mere duty, Granoff explains that the *Bṛhatkalpa-bhāṣya*—a sixth-century CE commentary upon the earlier *Bṛhatkalpa-sūtra* (c. first century CE)—details penalties for the *ācārya* and mendicants who fail to provide such care (2017, 31–34).[46] The penalties for medical neglect are based on the degree of harm incurred by a sick mendicant. Granoff explains:

> The penalty grows in severity as the harm done to the patient increases; the penalty is lightest if the patient is simply inconvenienced, greater according to the degree of suffering he endures, even more severe if he falls unconscious and greater still if he is in danger of his life. If the patient dies, the *ācārya* is to receive the severest penalty possible; he is to be expelled from the monastic community. . . . [M]onks who have failed to help their sick member are also subject to penalties. (34)

Alongside these penalties, the same commentary notably defines caring for the sick as a way to *destroy* karma (Granoff 2014, 237). This is a significant change that associates the duty to care with karma-burning austerities rather than with accumulating nonmeritorious or even meritorious karma.[47] In relation to this, it is emphasized that mendicants should not have any ulterior motives, such as receiving good meals, in providing care to the sick, bringing attention to intention behind offering service (237–38).

In accordance with such a strictly prescribed duty to care, a later, twelfth-century Sanskrit commentary on the *Bṛhatkalpa-sūtra*, written by Malayagiri and

Kṣemakīrti, claims that Jain mendicant communities care for their ailing fellow mendicants much better than other mendicant groups, such as the Buddhists, do for theirs (Granoff 2017, 23, fn. 2). This is a bold statement, considering the renown of the Buddhist monastic medical tradition, and it demonstrates just how far the notion of care for fellow mendicants had developed since the early strata of the canon that allowed only minor nonmedical accommodations for the ill.

What motivated the Jain community to establish so rigorously regulated mandatory services to sick members? Granoff suggests that "compassion, a sense of responsibility, and obedience to the commands of the Jina,[48] which were said to include tending the sick, might well have been the primary impetus behind attentive care of the physical illness" (2017, 24). To this list, however, she adds another major motivating factor, that is, safeguarding the wider mendicant community (24). As Stuart observes:

> The Jain communities as reflected in the commentaries perceived themselves as belonging to a religious minority whose very existence and survival was constantly under potential threat from rival religious sects, a persecuting ruler, war, famine, or displeased lay communities. Their numbers were already small and their existence precarious, yet they were appointed with the sacred task of maintaining the Jina's teaching and practice of non-violence in the world. If Jain monks and nuns are not treated when ill, and become physically or mentally compromised or die, the Jain tradition too is weakened and its teaching lost. (2014, 95)

This is at least partly aligned with the justification of religious healing in medieval didactic stories and narratives.

Granoff notes that in relation to the efforts aimed at protecting the mendicant community, the need to keep a patient satisfied is called attention to (24). The possibility of a dissatisfied patient who might pose a threat to the community hearkens back to the earlier warning within the *Sthānāṅga-sūtra*, mentioned above, that an *ācārya* who fails to provide proper care for sick mendicants can trigger communal disputes. Based on the *Bṛhatkalpa-sūtra* and its commentaries, Granoff explains why a dissatisfied ailing mendicant might prove a threat to the mendicant community as a whole:

> Dissatisfied with what their fellow monks were doing for them . . . [t]hey might hightail it out of the monastic community and make for the nearest householder, whom they might pester for medicines. This ran the risk of alienating the householder, upon whom the monks all depended for their daily necessities. Disgruntled patients might even badmouth their fellow monks or in a final act of anger, they might even disrobe. . . . A dissatisfied monk who disrobed would mean one less monk, but more importantly an angry patient could weaken the essential support of the laity. (2017, 24)

Granoff emphasizes that care for ill fellow mendicants was, consequently, twofold. First of all, illness needed to be attended to properly, but at the same time,

caretakers had to make sure that the patient was satisfied with the treatment and "felt that he was getting the best possible care" (2017, 24). In trying to address both of these demands—fulfilling the commitment to safeguard the reputation and unity of the community—the postcanonical commentaries show that mendicants occasionally broke their vows, such as the vow of nonpossession (e.g., by storing food and medications for the ill)[49] and truthfulness (e.g., by lying to patients or laypeople, sometimes even pretending that they were representatives of another tradition, such as Buddhism) (25–27; see also Granoff 2014, 238–39, 246; Stuart 2014, 82–83, 92). Stuart points out that the *Bṛhatkalpa-bhāṣya* even goes so far as to say that a seriously ill mendicant may consume any kind of food, be it Jain or not (BBh 1024–261; Stuart 2014, 77).[50] The texts show that these deviations are not reproached by the mendicant community, but are rather considered suitable behavior in specific circumstances.

Postcanonical mendicant texts also include complex discussions on who can treat a sick mendicant. In contrast to the strict prohibition of even such simple self-care as cleaning out a wound in the canonical sources, the postcanonical commentaries allow self-treatment when reasons for it are sufficient. Stuart cites the *Niśītha-bhāṣya* as an example of allowing a monk to clean and treat his own wound: "For the sake of the continuity [of scriptural learning]; for the sake of living beings; or so that he may die in *samādhi*, a monk conducts himself properly when washing etc., vigilantly" (NBh 1504; trans. Stuart 2014, 74). One reason behind this accommodation is the concern for the preservation of the Jain tradition and community, which was already discussed above. Stuart interprets the other two reasons as maintaining health in order to continue protecting living beings with one's religious practice, and in order to die "in a state of mental equipoise (*samādhi*) rather than aggravation" (2014, 74). In all cases, though, as emphasized in the text, a monk should remain vigilant in his conduct. In continuity with the canonical sources, the *Bṛhatkalpa-bhāṣya*, similarly, points out that "the religious life cannot be pursued without a body," highlighting the necessity of a relatively healthy body for the proper observance of religious practices, and thus justifying its medical treatment (BBh 2900, trans. Stuart 2014, 95–96).

Further, Deo asserts that if a monk or nun within the community was familiar with medicine, they were allowed to treat their fellow mendicants in times of illness (1954–55, 437; see also Stuart 2014, 75, 82). We can speculate that at least some mendicants were trained in medicine prior to their ordination, or they may have obtained medical knowledge in some other way (Granoff 2017, 26; Granoff 2014, 237–38). The *Vyavahāra-bhāṣya* encourages mendicant teachers to acquire medical training in order to be able to provide care to their students (VBh 2427–28; Stuart 2014, 76–77). Stuart points out that the monk who authored the *Bṛhatkalpa-bhāṣya*, for instance, "was both fascinated by and familiar with the world of medicine" (2014, 81). She notes that not only does his commentary reflect knowledge of specific medical treatments, *āyurveda*, and the doctrine of the three

humors, but it also lists eight kinds of doctors, of whom two are Jain mendicants, that is, one that is spiritually mature and the other that is not (82). Moreover, the *Niśītha-bhāṣya* refers to hospitals (NBh 3649), suggesting mendicants' familiarity with institutionalized medicine, and even "sanctions the monks' use of certain sharp instruments for removing splinters, thorns, or the venom of a snake" (NBh 3437; Stuart 2014, 73; see also 82). This is in direct contrast to the canonical texts, in which cutting into flesh for any minor reason, as discussed above, was prohibited.

Ideally, mendicants would treat only mendicants of the same sex, but in extraordinary circumstances, mendicants of the opposite sex were also permitted to provide care (Stuart 2014, 75–76, cf. 80). Mendicants could also ordain a person of the "third sex" (*paṇḍaka*; see chapter 5)—who was previously prohibited from taking vows—if that person was a physician (Stuart 2014, 83). Importantly, even mendicants without any knowledge of medicine were urged to offer their services to the sick. "There is always something that a monk might do to help," Granoff notes. "He might massage the patient, grind the medicines, stay up at night and keep watch" (2014, 238).

Some postcanonical texts note that certain patients are not physically able to fulfill the requirements of treatment. Granoff specifically mentions the example of rigorous fasting as a remedy for some illnesses. In such cases, alternative medication, such as restorative tonics, may be provided (2017, 27). Granoff, further, points out that fasting unto death was recommended for mendicants who could no longer properly observe their religious duties; however, if they were not able to undergo such a fast, they were entrusted to the care of the mendicant community, with strict rules for how long specific members and groups at various communal levels should provide it (2017, 35; see also Deo 1954–55, 437).

If no mendicants were capable of medically attending to a sick mendicant, a doctor had to be found outside the community (Granoff 2017, 26; Granoff 2014, 239). Granoff describes the hierarchy of preferred caretakers enumerated in the *Bṛhatkalpa-bhāṣya* in the following way:

> The doctor of first choice would be a Jain monk; the least desirable choice would [be] a doctor who is not a Jain but an adherent of another faith. . . . [T]his means a Buddhist or another type of renunciant. The author also prefers a doctor who is not wealthy or famous; they are too much trouble. Ever practical, however, the text allows that if there is no competent Jain doctor, monk or layman, the monks should seek out the most competent person, regardless of his religious persuasion. (2014, 239)

Seeking medical care from a householder physician who was a relative of the ailing mendicant was considered an appealing option because this way the treatment did not have to be paid for. However, it was also considered a dangerous choice, as the ailing mendicants' families might try to reclaim them while they were seeking treatment (Granoff 2014, 241; Granoff 2017, 27–28; see also Stuart 2014, 75). In line

with this, some texts emphasize that only mendicants who are very firm in their commitment to their renunciant life can seek such care (Granoff 2017, 28–29).

Regular householder physicians, on the other hand, required payment, which posed additional problems for the mendicant community, since Jain mendicants are not allowed to possess money. If they cannot convince the doctor to offer medical services for free, by appealing to having no possessions, the texts state that they may either use the possessions that have been renounced by a mendicant who had been wealthy as a layperson; find wealth buried in a secret place with the aid of mendicants with extraordinary cognitive abilities; go on alms rounds asking specifically for donations they can pay the doctor with; and offer various services and skills in exchange for money (Granoff 2014, 244–45; Stuart 2014, 86).[51] Another concern that emerges is how mendicants without possessions may offer a comfortable stay and other proper services to the doctor who is visiting in order to provide medical care to a mendicant patient. The texts offer a broad range of accommodations, including being allowed to bathe and massage the doctor, as well as arrange for a special meal, prepared either by householders or, in certain circumstances, even by the mendicants themselves (Granoff 2014, 243, 245–46; Stuart 2014, 83–87). One solution to these medical challenges was reliance on the help of former mendicants who had returned to lay life, called *paścātkṛta*s (Granoff 2014, 229, 232). Although early texts were extremely critical of monks who left the fold, by the postcanonical period, *paścātkṛta*s were essential intermediaries between mendicants and householders, and they were particularly helpful in the case of providing medical care for sick mendicants, for example by assisting in interactions with physicians (229, 235, 237).

In seeking the most proper physicians and care providers for ailing mendicants, the postcanonical texts suggest, as Stuart points out, that the "concern is not medical care itself, but simply the potential for association and physical intimacy with members of the opposite sex—or monastics' association with heretics and householders" (2014, 75). The continuous underlying worry is that such associations may bring mendicants to renounce their vows and leave their mendicant life (Granoff 2017, 28).

While the postcanonical texts and the early canonical sources seem to be divided by a large gap at first sight, we can see several lines of continuity between them. It seems that the early emergence of the duty to care and the idea of the body as an instrument of spiritual progress may have set the precedent for the later developments. The open recognition that mendicants do get ill generated a whole new set of concerns rooted in the desire to keep the community stable as well as ensure the mendicants' ability to properly perform their religious practices. With this, care for the sick became an obligation and a sign of a compassionate, loyal, and dedicated mendicant. Medieval didactic stories and narrative literature, on the other hand, retain a stronger tension between the treatment of illnesses and the ultimate goal of liberation, reminiscent of the early portions of the canon.

Digambara Sources

Digambara sources are much less explored than those of the Śvetāmbara tradition in relation to medicine and the medical treatment of mendicants. We know of no study in English that overviews the Digambara medical textual sources, and only one text, the *Kalyāṇa-kāraka* (on which more shortly), is slightly better researched. Since the Digambaras consider their canon to be lost, the sources that describe medicine are all postcanonical (see chapter 3). In light of this, we will here offer only a few remarks on these sources based on a small number of selected texts, paying particular attention to the continuities and discontinuities with the Śvetāmbara sources that have been discussed so far.

There is an indication in some texts that Digambara attitudes toward the medical treatment of mendicants may have undergone a development that parallels the Śvetāmbara sources. For example, we see the tension between the emphasis on abandoning the body, on one hand, and maintaining the body for religious practices as well as offering services to the sick, on the other, exemplified in Pūjyapāda's sixth-century *Sarvārtha-siddhi*, a Digambara commentary to the *Tattvārtha-sūtra*. The root-text and the commentary stress the importance of enduring twenty-two hardships (*parīṣaha*) (TS 9.9), including illness (*roga*) and injury (*vadha*) (see chapter 3). Here, Pūjyapāda attempts to reconcile the importance of the body as a vehicle on the path of purification with a detached attitude toward the body. He describes the body as "the repository of everything impure (*sarva-aśuci-nidhāna*), impermanent (*anitya*), and defenseless (*aparitrāṇa*)" (SSi 9.9§830). In line with this, an ascetic is neither to think of the body nor adorn it. At the same time, Pūjyapāda likens the body to an essential tool in need of maintenance, drawing an analogy between an ascetic eating food and taking care of an axle or applying ointment to a wound. It is interesting that he uses the example of the wound (*vraṇa*), the treatment of which was, as discussed above, prohibited in the Śvetāmbara canon.

Should ascetics fall ill due to unsuitable food or drink, they are supposed to endure the illness. Pūjyapāda notes that an ascetic may have, through the practice of various austerities, attained extraordinary powers, such as *jallauṣadhi*. Wiley explains that "*jalla* means impurities (*mala*) originating from the ears, mouth, nose, eyes, tongue, and the body. By this attainment these impurities become pleasant smelling and cure all diseases" (2012, 160).[52] Pūjyapāda stresses that despite possessing healing abilities, ascetics should not use them to cure themselves, paralleling the reluctance to cure oneself through religious healing in medieval didactic stories and narrative literature discussed above.[53]

However, both the root-text and the commentary also describe an internal austerity of service (*vaiyāvṛttya*) to the sick (*glāna*) (TS and SSi 9.20, 9.24; see chapter 3). Pūjyapāda defines "service" as "attending to" (*upāsana*) with bodily activity (*kāya-ceṣṭā*) and other things (*dravya-antara*) (SSi 9.20§862). He further notes that service is done for the purpose of effecting *samādhi* (*samādhi-ādhāna*),

dispelling of doubt (*vicikitsā-abhāva*), and expression of affection (*pravacana-vātsalya*), among others (SSi 9.24§866). Medical treatment is not explicitly mentioned, and it seems that *service* here refers primarily to nonmedical help. Service is, additionally, considered as being aligned with the spiritual path, even leading to spiritual attainments. In this regard, the commentary resembles the late Śvetāmbara canonical sources better than the postcanonical mendicant manuals. This again highlights the function of different literary genres, noted above.

However, the absence of an explicit reference to medical treatment does not mean that Digambara sources rejected the use of medicine entirely. On the contrary, it seems that Digambara texts view not only service but also medical gifts in a positive light. The *Trilokaprajñapti* (Pkt. *Tiloyapaṇṇatī*), composed by Yativṛṣabha around the sixth to seventh centuries CE (roughly the same period as the Śvetāmbara commentaries explored above), suggests that people who give the gift of medicines (*auṣadhi-dāna*) may earn auspicious rebirth in the *subhoga-bhūmi* lands of the cosmos (Wiley 2000a, 59), linking medical provision with auspicious karma.[54] The possibility of beneficial rebirth suggests that medical care was, at least to a certain extent, also promoted.

These few textual examples indicate that Digambara sources contain similar themes and considerations to Śvetāmbara sources when it comes to medicine and medical treatment. Further research in Digambara sources is needed in order to more precisely identify similarities and differences.

Jain Medical Treatises

According to the Jain tradition, the earliest canonical scriptures contained knowledge about illnesses and their treatment. *Prāṇa-vāda* (Pkt. *Pāṇā-vāya*), the twelfth Pūrva, is supposed to have discussed medical topics and contained an account of eight kinds of medical science. Wiley identifies these as "the eight *aṅga*s of *āyurveda*" (2000a, 268). As the twelfth Pūrva is lost, it can, however, only be speculated what the version of medicine imparted by this text was and in what ways it reflected specifically Jain ethical values.

Much research still needs to be done on the history of Jain medical treatises. Gerrit Jan Meulenbeld's extensive, five-volume *History of Indian Medical Literature* and R.P. Bhatnagar's *Jaina Āyurveda kā Itihāsa* are rich resources for future scholarship in this area. In part 2 of this book, we will mainly refer to two medical treatises that have already received some, albeit limited, scholarly attention: the Śvetāmbara *Taṇḍula-vaicārika* (Pkt. *Tandula-veyāliya*), written in Prākrit (post–seventh century CE) and the Sanskrit *Kalyāṇa-kāraka* (c. ninth century CE), written by the Digambara monk Ugrāditya. The *Kalyāṇa-kāraka* is presently available only in Hindi translation. The *Taṇḍula-vaicārika* was translated into French as a two-part analysis by Jain studies scholar Colette Caillat; Brianne Donaldson has recently published English translations of Caillat's work (Caillat 2018, 2019).

The *Taṇḍula-vaicārika* is a short treatise belonging to a collection of the Prakīrṇaka-sūtras or "Mixture" texts that exist on the margin of the Śvetāmbara canonical corpus. The title refers to the total "grains of rice" that a male individual consumes over the course of a hundred-year life span. The text includes descriptions of embryology, gynecology, anatomy, the duration of life, and the inevitability of disease and death (Caillat 2018, 2019). In her analysis of the treatise, Caillat claims that "the teaching [that the *Taṇḍula-vaicārika*] dispenses recalls, without being identical to, elements of classical Indian medicine" (2018, 4).

The Digambara *Kalyāṇa-kāraka* of Ugrāditya seems to be the most detailed and comprehensive extant manual on Jain medicine, consisting of twenty-five, and two additional, chapters, and roughly eight thousand verses and some prose. The text proclaims medicine as something innate to the Jain tradition, claiming that āyurvedic knowledge originated with the first Jina Ṛṣabha, who passed it on to the first universal emperor (*cakravartin*) Bharata, from whom it was passed to each subsequent Jina, teacher, and student (Meulenbeld 2002, vol. IIA, 151).[55]

Ugrāditya claims to have consulted earlier Jain medical texts, but unfortunately none of these seem to be extant (Ghatnekar and Nanal 1979, 94). He describes the *Kalyāṇa-kāraka* as an abbreviated version of an extensive text on the eight limbs of *āyurveda* by Samantabhadra (KK 20.86), while claiming the ultimate source of all medical works to be the *Prāṇā-vāda* mentioned above (KK 21.3, 25.54). Meulenbeld explains that Ugrāditya belonged to the mendicant lineage of the eminent Digambara philosopher-monk Kundakunda (2002, vol. IIA, 155), a pedigree suggesting that medicine was fully accepted in Digambara circles by the ninth century.

Like the *Taṇḍula-vaicārika*, the *Kalyāṇa-kāraka* is in conversation with the classical āyurvedic treatises of the time, but also adds its own Jain twist by removing three forbidden foods (*vikṛti*) of honey, alcohol, and meat from the accepted lists of medicines. Rao suggests that the removal of meat and alcohol from medical treatments "assumes a position against even *Caraka* in this regard" (1985, 64). He continues:

> Diseases (*āmaya*) and meat (*māṃsa*) are both alike caused by sin (*pāpajatvāt*), by the three *doṣa*s, and by the involvement of bodily constituents (*mala-dhātu-nibandhanāt*), and, therefore meat cannot be employed to cure a disease (*na pratīkārakam*). . . . The work recommends only the medicines derived from the vegetable kingdom, and that too in little quantity (*svalpam*) and taken in an agreeable manner (*sukham pathyatamam*). (64)

The *Kalyāṇa-kāraka* also prohibits honey as a medical treatment since it is a substance that consists of infinite minute beings. Other substances of animal origin can be used, however, such as hair, nails, bones, or excrement (Meulenbeld 2002, vol. IIA, 152). The text addresses many topics, such as prognostics, embryology, anatomy, obstetrics, and various modes of treatment, including sixty kinds of

therapeutic procedures, directions for taking drugs, bloodletting with leeches, and alchemy.[56]

JAIN FOUNDATIONAL PRINCIPLES IN MEDICINE

There is little scholarship addressing Jain views on medicine and medical practices in the canon. However, the canonical texts reveal a period of dynamic change within the Jain community that led to accommodations and duty to care for sick mendicants within circumscribed regulations, and these adaptive practices possibly opened space for the later liberalization of medicine within the postcanonical period. The examination of the development of the Jain approaches to medicine and medical treatment highlights several foundational principles that must be considered within any contemporary engagement between Jainism and bioethics. These principles establish fundamental attitudes toward the understanding of illness and the body, the relation of illness and the body to mendicant practice, the karmic costs and/or benefits of medicine, and the social dimensions of medical treatment.

First, the body is an essential instrument upon the path to liberation. Each individual body is the product of past karma, and each body is also the medium through which one strives toward karmic advancement in one's present existence. Jain texts encourage mendicants to overcome—often through rigorous physical austerities—attachments to the body itself, to its beauty, comfort, or longevity. One who can practice equanimity in the face of bodily illness or discomfort, can attain immense spiritual gains. Nevertheless, Jain texts also recognize that ascetic disciplines require a body healthy enough to withstand the efforts, and that illness can impede that progress.

Second, physical illnesses are said to affect the gross physical body of those beings living in the "lands of action" and to have diverse causes. Physical illness is produced through karma associated with pain or unpleasant experiences, karma causing disfigurement or self-destruction, disturbances in the three bodily humors, damaging lifestyle habits, ascetic powers, human and divine curses, or the decline in vitality due to old age. Mental illness may be caused by delusion-producing karma, possession by a *yakṣa*, or an imbalance of the humors. Depending on the cause, illnesses of various types can be more or less responsive to treatment, modification, and improvement. For instance, adjusting lifestyle habits is said to alleviate many health issues. Conditions affiliated with karma, however, may require an entire lifetime to influence through severe austerities.

Third, Jain approaches to medical treatment vary. In the earliest texts, disciplined, individual mendicants were expected to forgo medicine, medical treatment, and using their own skills to heal others or themselves. Receiving and providing medical treatment was deemed a source of attachment (*parigraha*) and violence (*ārambha*). However, these costs could eventually be accepted for ill mendicants

for the sake of communal health and stability, so long as they were regulated with additional rules. The texts record a gradual emergence of a duty to care, first by mendicants collecting alms for sick fellow mendicants and circumscribing specific situations when sick mendicants could violate communal rules, and eventually providing and/or procuring medicines or treatment that would keep the community stable and patients satisfied. In order to provide care for the sick, Jain mendicants could even violate certain vows such as storing food or medications for the sick. Nevertheless, some texts, especially didactic stories and narrative literature, express a persistent unease in encounters with healing.

Fourth, the understanding of the effects of caring for the sick is likewise not uniform. In the texts, caring for ailing mendicants transforms from a karma-accumulating activity to a karma-destroying practice that aids one on the path of purification.

Fifth, and finally, the notion of an acceptable medical provider expanded from the early canon through the postcanonical period. Doctors and other householders were decried as violent and deluded in the earliest texts. However, the need to safeguard community health meant that mendicants could eventually provide care for themselves and their fellows. The view of householders also gradually softened as the dependence of the mendicant community on householders deepened, and if no mendicants were available to provide medical care, doctors were regarded as suitable to offer medical services. In the postcanonical period, a formal hierarchy of healthcare providers begins with Jain mendicants themselves (who may have been physicians prior to ordination), to Jain former mendicants, to Jain householder physicians, and finally to non-Jain providers. Jains also developed their own medical treatises and contributed to the wider medical literature of the time.

In part 2, we will explore contemporary views of medicine that draw upon insights from the canon and from postcanonical texts, as well as from individual Jains' personal and clinical experience. Drawing upon the foundational principles we have identified in part 1, we attempt to distinguish principles of application that can inform a Jain engagement with modern bioethics.