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Shvetapradara –
**Negotiating Ayurveda and Biomedicine in Contemporary
Ayurvedic Gynecology**

by Linde S. Goebel



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Master's Thesis

**Shvetapradara:
Negotiating Ayurveda and Biomedicine in Contemporary
Ayurvedic Gynecology**



submitted in partial fulfillment of the requirements for the degree of
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by

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Declaration

For submission to the Examination Committee
regarding my Master's Thesis with the title:

**“Shvetapradara: Negotiating Ayurveda and Biomedicine in Contemporary
Ayurvedic Gynecology”**

I declare that

- 1) It is the result of independent investigation.
- 2) It has not been currently nor previously submitted for any other degree.
- 3) I have not used sources other than the ones mentioned in the bibliography.
Where my work is indebted to the work of others, I have made
acknowledgments.

Heidelberg, 24th of September 2013

Linde Goebel

कृत्स्नो हि लोको बुद्धिमतामाचार्यः शत्रुश्चाबुद्धिमताम् ।
(चरक संहिता, विमान स्थानम् ८.१४)

The wise consider the entire world a teacher,
to the ignorant it is an enemy.
(Charaka Samhita, Vimanasthanam 8.14)

Summary

Leukorrhoea, an increased amount of vaginal discharge, is a common complaint for which women - especially in India - seek the help of medical practitioners. Considered by some to be the female equivalent to the culture-bound syndrome of semen loss anxiety (*dhat* syndrome) of South Asian men and by others an idiom of distress, ayurvedic concepts of the body are often cited as the underlying cause of Indian women's undue concern with it. It has been suggested that ayurvedic doctors recognize and treat *shvetapradara*, the ayurvedic equivalent of leukorrhoea, as a disease which could have serious consequences if left unattended, but literature on the actual practice of the *vaidyas* of contemporary institutionalized and professionalized Ayurveda is rare, and ayurvedic gynecology as a separate branch of what constitutes Ayurveda in India today has not received any attention so far. I attempt a step into the direction of filling this lacuna by investigating into the practice surrounding white vaginal discharge in a government Ayurveda university hospital in North-West India. By taking on a praxiographic approach I follow *shvetapradara* through different sites and contexts within one university hospital, exploring the *vaidyas'* practices and academic work surrounding it, the materialities involved, both the scope and restrictions defining their practice and subsequently the object enacted.

I undertake this investigation of leukorrhoea to approximate the meaning and facets it carries in ayurvedic health care, and arrive through this process at a reflexion of contemporary professional ayurvedic practice - which is in its amalgamation of biomedical and ayurvedic aspects the result of colonial and post-colonial standardizing educational reforms of the 19th and early 20th century - and the implications this carries for anthropological research.

I conclude that what goes under the name of *shvetapradara* in modern ayurvedic practice is a multiplicity of objects, whose identities differ according to their context, but are not congruent with what anthropologists and cross-cultural psychiatrists refer to in the context of *dhat* syndrome and somatization.

Elsewhere the coordination of multiple objects carrying the same name into a singularity has been described as necessary to escape the threat of incommensurability looming on the horizon when either two fundamentally different systems of medicine meet, or multiple objects of different identities carry

the same name. I instead propose with regards to the study of modern institutionalized and professionalized Ayurveda that it be studied as its own system of medicine. Its specific way of using the language and practice of both Ayurveda and biomedicine deserves to be studied in its own right and without being reduced to two incommensurable parts. Modern professional Ayurveda in India is constituted of ayurvedic and biomedical aspects, but the whole of it is different than the sum of its parts.

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1 Prologue

It is a Saturday morning shortly before 9 o'clock on the campus of one of the country's largest Ayurveda universities, North-West India. The asphalt of the short road leading from my domicile, the students' hostel, to the teaching hospital is reflecting the heat of the relentless Indian April sun as if the night had never brought relief from it. The watchman has already pulled his plastic chair into the shade of a yellow blossoming tree, and the street dog who found a home with him lies motionlessly in a pit dug into the slightly cooler ground. As I approach hospital J and the all too familiar smell of Dettol disinfectant, sewage and earthy ayurvedic oils greets me before I even enter, I wonder for a short moment what made me come back to do fieldwork in the place I left almost 3 years ago with both a degree in ayurvedic medicine and the certainty to not return for longer than a fleeting visit.

The thought vanishes quickly though as I am drawn into the humming activity of the out-patient department [OPD] building: Patients wait under the hospital's canopy in front of cross-barred windows for their turn to receive the case papers, separated into lines according to gender and whether they are an "old case" or a "new case". It is here they are registered: name, age, sex, place, OPD number. The benches set up in the entrance hall of the hospital building are still empty – they are the waiting area of the dispensary, which will give out free ayurvedic pills and powders, oils and ashes according to the *vaidyas'* prescriptions once the patients have been consulted, examined and diagnosed. For now, the patients occupy two corridors, sitting on more benches and sometimes the floor, in front of doors that open off the hall. Behind each door is the consultation room of one of nine different departments, and in case one is not sure where to go, or not familiar with the Sanskrit-name of the departments spelled out in Gujarati and Latin letters on hand-painted blue and white signs hanging above each door frame, one can consult a round rack with mounted wooden posters near the entrance.

The one for where I will spend the next 10 weeks, the *Stri Roga* and *Prasuti Tantra* [gynecology and obstetrics] department, shows the painting of a fair-skinned woman in a red sari holding a little boy, and it reads in Gujarati: "Room nr. 8, *Prasuti, Stri Rog* department. Treating diseases of the vagina, discharge of white water, diseases related to menstruation, diseases developed after the

cessation of menses (menopause), attending to those who can't conceive, the pregnant and puerperae, and to miscarriages”.

A nurse is sitting on a chair in front of room number eight collects the case papers of the women who want to see an ayurvedic gynecologist and places them in a stack on the doctor's desk in the little consultation room of approximately 12 square-meters, which is still quiet: The ayurvedic scholars and their professors have not yet completed the morning round in the adjoining building's inpatient departments.

The heavy desk with its impressive imitation leather swivel chair covered with a thick woven towel is the center of the room, it is covered with a *khadi*¹ table cloth - pink flowers on white ground - and an ill-fitting sheet of glass, between the two are conveniently held in place lists of staff phone numbers, advertisements of Ayurvedic proprietary medicines, instructions about how to fill out the case sheets, and most importantly the no-stock list, indicating which medicines can not be prescribed until the new supply reaches the pharmacy department. Still neatly arranged, and not half an hour later scattered all over the desk, are registers, various forms for referrals, a ruler, a puncher, a stapler, an ink-pad, two chipped paper weights out of glass, and a hotel reception bell. Around the desk cluster three chairs with cushions for the MD and PhD scholars, a narrow wooden bench for BAMS² interneers or visitors and three metal stools for patients. A hospital trolley functioning as a shelf for forgotten case papers, forms and plastic cups for urine pregnancy tests in one corner of the room, a cot for ante-natal check-ups behind a green rumped curtain in the other – and there is, it seems, not much space in the small room left.

Not even ten minutes later though the small consultation room is crowded with patients – women of all ages, creeds and casts, accompanied by children, mothers, sisters, sometimes husbands – clustering around the professor and her scholars, who are all registered ayurvedic practitioners and now on their way to an MD or PhD in ayurvedic gynecology and obstetrics. Consultations, fetal heart sounds, urine pregnancy tests, blood pressure measurements and expecting mothers' weight gain are all attended to simultaneously. Some of the scholars ask me if what they have heard is true, that I am a BAMS graduate who has come

¹ A coarsely woven cotton cloth

² Bachelor of Ayurvedic Medicine and Surgery

back for research, and as I confirm I am handed an empty case sheet and allotted one of the waiting patients with the order to take her case history, since every help is needed now. Even though I should probably appreciate my quick entry into the field, I am at once overwhelmed: Suddenly I remember nothing of my Gujarati vocabulary and have forgotten the specific way cases are taken here. I came ready to observe with what I thought was the mindset of an anthropologist, but as I realize in precisely this moment, I am unprepared to participate in the most direct way an anthropologist studying ayurvedic practice can do – to fill in the position of an ayurvedic physician, a *vaidya*³.

2 Introduction

In 2010, the number of *vaidyas* in India registered with their respective state's board of ayurvedic medicine requiring at least the five and a half years Bachelor of Ayurvedic Medicine and Surgery (BAMS) amounted to 478,750, who work at the nation wide 2,458 government Ayurveda hospitals (Chandra 2011: 148) and numerous other private clinics. Seventy to eighty percent of Indians depend on traditional health-care systems (Gogtay et al. 2002: 1006 quoting Lele 1999), out of which Ayurveda is the commonest by far (Gogtay et al. 2002: 1007). The hospital I conducted fieldwork in for ten weeks in the spring of 2013 is a teaching hospital belonging to one of India's government Ayurveda universities, with an influx of patients comparable to that of the National Institute of Ayurveda in Jaipur, Rajasthan, which registers an average of 500 patients in their out-patient departments every day and averagely admits 2500 patients into their in-patient departments (IPDs) each year (Chandra 2011: 153).

During the time of my research in a university hospital's department of ayurvedic gynecology and obstetrics the number of women visiting during the OPD hours was around thirty on slow mornings, and up to a hundred on the week's busiest day, Saturday. Admitted to the department's share of beds in the female ward of the hospital were eight to ten women at a time including women suffering from gynecological disorders or complications of pregnancy, and women in labor or puerperium. Since professionalized and institutionalized Ayurveda education,

³ Throughout this work I adopted a simple spelling of the words from Indian languages leaving aside diacritical marks.

research and practice has been modeled after its biomedical counterparts (as I will describe in chapter 3 in greater detail), and is fostered by the government of India, the department fulfills – apart from its ayurvedic assignment – tasks of government programs regarding mother and child welfare and family planning, such as the regularly required ante natal checkups and ultrasonographies, the distribution of oral contraceptives, and insertions of copper-Ts. Based on the patient numbers and its areas of responsibilities as a government hospital where patients receive free medical care, the *Stri Roga* and *Prasuti Tantra* department plays a conspicuous role in the city's health care options for women – as for instance those suffering from from what I have come to study in the context of modern Ayurveda: white vaginal discharge, in the vernacular known as *safed pani* (lit. white water), diagnosed as *shvetapradara* (Sanskrit: white discharge) by ayurvedic *vaidyas*, and correlated by them with biomedicine's leukorrhea.

Safed pani has received scholarly attention by anthropologists and cross-cultural psychiatrists due to the fact that vaginal discharge is a common complaint of women especially in India (Koenig et al. 1998, Joshi et al. 2008), but the rate of Indian women suffering from reproductive tract infections is much lower than earlier assumed (Brabin et al. 1998). If the presence of a bacterial or viral pathogen causing cervical or vaginal infections and inflammations is ruled out, and the vaginal discharge is therefore of normal composition, it is from the biomedical point of view most often considered a physiological (not pathological) phenomenon due to hormonal changes in the woman's monthly cycle or stage of life, or as a natural defense of the female body balancing the vaginal pH value.

In the illness experience of Indian women though, such kind of non-infectious vaginal discharge occupies an important place: In a study conducted by the Indian psychiatrist Chaturvedi in 1988, Indian Women presenting the complaint of *safed pani* were highly worried about the vaginal discharge, were not easily calmed down or convinced of the harmlessness of their condition, and saw the vaginal discharge as a loss of vital fluid. This and other studies led cross-cultural psychiatrists to believe that South Asian women's abnormally high concern with their normal vaginal discharge could be the equivalent to South Asian men's *dhat* syndrome (Chaturvedi et al. 1993; Singh et al. 2001), a neurotic and depressive disorder based on the fear of semen loss accompanied by various somatic complaints (Bhatia & Malik 1991: 692; Akthar 1988: 70). Other psychiatric labels of

Indian women's preoccupation with vaginal discharge are 'folk model model of depression and anxiety' (Patel and Oomann 1999) and 'psyaestenic syndrome' (Chaturvedi 1988). Anthropologists determined it to be an 'idiom of distress' (Nichter 1981 & 2010), a 'communicative agent of the self' (Trollope-Kumar 2001a) and a 'bodily idiom of communication' (Trollope-Kumar 2001b). Commonly cited as a root cause for the women's associations of vaginal discharge with a depletion of a vital tissue of their body by both psychiatrists and anthropologists is ayurvedic thought, which is underlies Indian assumptions about body and health (Kakar 1982: 210), and it has been suggested that *vaidyas* recognize and treat *shvetapradara* as a disease which could have serious consequences if left unattended (Trollope-Kumar 2001b).

In this thesis I will investigate – based on Mol's praxiographic approach to diseases (2002) - into the ayurvedic practice surrounding leukorrhea in a government Ayurveda university hospital in North-West India. I will explore white vaginal discharge in the light of how *vaidyas* trained according to a syllabus containing a large amount of biomedical contents are working and conducting research in a clinical and ideological environment incorporating both Ayurveda and cosmopolitan medicine. I deem an anthropological study of leukorrhea within this modern practice of Ayurveda as especially utile, as its negotiation in such a syncretic setting can raise questions regarding both the ontological classifications of illness and disease, and the prevalent anthropological discourse about contemporary institutionalized Ayurveda.

Apart from literary sources, I draw in my writings upon ten weeks of fieldwork, which consisted of participant observation in the *Stri Roga* and *Prasuti Tantra* in- and out-patient departments, treatment-, labor- and class rooms, and its operation theater, and semi-structured interviews conducted in the professors' offices, the department's library, and the scholars' common room.

In the following chapter I introduce the research question and provide its context by reviewing relevant literature regarding leukorrhea on one hand and institutionalized and professionalized Ayurveda on the other. In chapter four I lay out the theoretical approach underlying my investigation into the practice surrounding vaginal discharge in a contemporary ayurvedic university hospital. Chapter five begins with a description of my entry to the field site, then delineates

the research methodology I employed, and concludes in a reflection about my role as an anthropologist and the challenges I met with during my fieldwork.

In chapter six I present a consultation of a *vaidya* with a patient of *shvetapradara* and scrutinize if substantial ayurvedic concepts are still central to the *vaidyas'* thinking and their practice, even though they have seemingly faded into the background in the hectic daily practice of a government hospital. Chapter seven starts with the description of an examination of a *shvetapradara* patient followed by the prescription of ayurvedic medicines, which prompts me to address one of those medicines - a tablet called *chandraprabhavati* - and the meaning it carries in detail. In chapter eight I follow *shvetapradara* and one of its patients into the surgical theatre of the ayurvedic hospital, which leads me to touch upon issues regarding translations between Sanskrit and English in Ayurveda, and ultimately to explore the line of argumentation of an ayurvedic MD scholar's thesis as part of the knowledge producing practices in a teaching hospital.

3 The Research Question and its Context

The research presented here is an inquiry into contemporary professional ayurvedic practice at the example of the negotiations surrounding the symptomatology of leukorrhea⁴ in the day-to-day practice of an university hospital's gynecology department in North-West India. I concentrate on the ayurvedic doctors' practices regarding their patients' complaint of white vaginal discharge to explore what meaning the disease entity *shvetapradara* carries in ayurvedic practice. Biomedical and ayurvedic concepts and practices are both inherently present in the complex discourse and working conditions of a modern ayurvedic government hospital and the teaching institution it is usually attached to, as colonial and post-colonial educational and political reforms have resulted in a curriculum which integrates both systems of medicine and is taught nation-wide since 1976 (Chandra 2011: 10). Practitioners of Ayurveda, therefore, who have graduated from one of the institutions recognized by the Indian government, are familiar with the languages and concepts of both cosmopolitan medicine as well as the tradition of Ayurveda and could be said to operate in a field of tension between two conflicting epistemologies.

⁴ The definition of leukorrhea applicable here will be elaborated on page 12

I will explore as what kind of entity leukorrhea, which falls into different classifications according to the context it is described in (a feature of a culture-bound syndrome rooted in ayurvedic thought according to psychiatry, depending on its definition a symptom for physiological or pathological processes of the body according to biomedicine, a serious depletion of a precious body tissue which needs medical attention within Ayurveda according to anthropologists), emerges from a medical practice, whose practitioners are trained in both biomedicine and ayurvedic medicine. I undertake this investigation of leukorrhea to approximate the meaning and facets it carries in ayurvedic health care, since it is here the cause of South Asian women's undue concern with it is often located. I arrive through this process at a reflexion of contemporary professionalized ayurvedic practice in general and the implications this carries for anthropological research specifically.

I reconsider if modern *vaidyas* are in fact juggling with two different epistemologies they are forced to reconcile in view of what is at stake (Leslie 1992), if they have to straddle two cognitive universes (Naraindas 2006) and if are they forced to bridge two incommensurable systems to be able to enter the medical discourse dominated by cosmopolitan medicine (Sujatha 2011).

In the following I will elaborate on the two above broached issues, which are prominent with regards to the focus of my research and its implications: Leukorrhea and institutionalized and professionalized Ayurveda.

3.1 Leukorrhea – Safed Pani – Shvetapradara

What sparked my initial interest in leukorrhea were medical anthropology's and cross-cultural psychiatry's discussions surrounding *dhat* syndrome, the fear of semen loss in South Asian men, which was initially categorized a “culture bound sex neurosis of the Orient” (Malhotra & Wig 1975:519) and later listed in the 4th edition (text-revision) of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2000) under Culture-Bound Syndromes, and in the 2010 version of ICD-10 under Other Specified Neurotic Disorders (F48.8, WHO 2010).

The fear of semen loss in *dhat* syndrome is accompanied by various other complaints, such as anxiety, body-aches, and feelings of weakness. The anxiety occurs irrespective of the semen being lost in frequent sexual intercourse,

masturbation or involuntary nightly emissions, and the semen is believed to be excreted with urine as an outcome of previous sexual activities. It typically affects men of the lower or middle socio-economic class with a poor education on reproductive health and a conservative outlook on sexuality (Bhatia & Malik 1991: 692; Akthar 1988: 70). *Dhat* syndrome is considered a culture-bound syndrome as the fear of losing a substantial element by genital discharge is argued to be based upon cultural and traditional medical cognitions of India (Bhatia & Malik 1991, Akthar 1988).

The same cognitions are held responsible for what is described as the female equivalent of *dhat* syndrome: Non-infectious leukorrhea, an excessive physiological vaginal discharge (Karasz et al. 2007: 488; Trollope-Kumar 2001a: 262 and 2001b; Patel et al. 2008: 261). An increased amount of non-infectious vaginal discharge is a common complaint for which Indian women seek the help of medical practitioners (Koenig et al. 1998, Joshi et al. 2008). Different from infectious leukorrhea, its non-infectious counterpart does not show the presence of a causing bacterial or viral pathogen, but occurs - according to biomedical explanations - due to physiological hormonal changes in the woman's monthly cycle or stage of life, or as a natural defense of the female body balancing the vaginal pH value. Because this is considered a physiological, not pathological, phenomenon it does not need medication.

The illness narratives and causative correlations of Indian women who consider their non-infective vaginal discharge to be excessive and seek health care for their problem closely resemble male patients' ideas about the loss of reproductive fluids responsible for subsequent weakness (Patel et al. 2008). In a study conducted by the Indian psychiatrist P.K. Chaturvedi in 1988, Indian Women presenting the complaint of white vaginal discharge showed symptoms of anxiety and depression and saw the vaginal discharge as a "loss of vital fluid" (Chaturvedi 1988:70). This and other research (for example Chaturvedi et al. 1993 and Singh et al. 2001) suggests, that non-infectious white discharge per vagina is the female equivalent of *dhat* syndrome, which despite all the attention in psychiatric (quoted above) as well as anthropological work has not yet found its way into the ICD or DSM.

Looking further into women's experience of medically unexplained vaginal discharge Patel and Oommen found that it might represent a 'folk model of depression and anxiety' (1999: 34) in India and talking about physical symptoms

may be much easier for patients than to disclose mental turmoil. Chaturvedi et al. (1993) highlight that the process of somatization, which is typical for patients with common mental disorders and underlies the health seeking behavior of women with vaginal discharge, is the product of a misattribution, in which the patient experiences psychosocial stress situations physically as vaginal discharge, body aches and weakness (for which no medical reasons can be found). Medical anthropologists have looked at leukorrhea from a similar angle and through a focus on illness narratives of patients described it as an 'idiom of distress' (Nichter 1981) or a 'bodily idiom of communication' (Trollope-Kumar 2001b), in which psychosocial distress is communicated through somatization for a lack of better ways of expressing them.

To allot a clear cut definition to the three terms often used synonymously – *safed pani*, *shvetapradara* and leukorrhea – is a task that got more and more complicated the deeper I delved into both the literary review of my subject as well as the fieldwork, probably an indicator of what a careful investigation the meaning of words require when one is working at the interface of different cultures and systems of medicines.

Safed pani is the term used by women who suffer from any type of vaginal discharge to describe their condition, and *shvetapradara* is the Sanskrit word equivalent to 'white discharge', a common diagnosis *vaidyas* arrive at (at least in hospital J) when women complain of *safed pani* - if specific other conditions are ruled out first. The term *shvetapradara* appears in the classical Sanskrit texts (the commentator of Charaka for example, Chakrapanidatta, uses it to explain what Charaka means with his expression *pandura asrgdara*⁵), but the lines between symptom and disease are blurred in this case and subject to the interpretation of the *vaidya*.

Expecting an unquestionably clear definition of leukorrhea in textbooks of cosmopolitan medicine, I met with ambiguity: Western biomedicine defines leukorrhea as a “flow of a whitish, yellowish, or greenish discharge from the vagina of the female that may be normal or (...) a sign of infection” (Encyclopedia Britannica n.d.) and therefore can be a symptom of an underlying infection of vagina or cervix, an early indication for benign conditions, or due to pelvic

⁵ Chakrapanidatta on Charaka Samhita, Chikitsastahanam 30.116. *pandura* = white, pale; *asrgdara* = discharge of blood, but in this context probably only discharge.

congestion (Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health 2003). The Indian allopathic textbook mainly studied (but not always adhered to) by the ayurvedic scholars practicing in hospital J however classifies Leukorrhoea as abnormal vaginal discharge, but only with regards to its quantity and states: "Leukorrhoea is strictly defined as an excessive normal [referring to its composition] vaginal discharge. To declare it to be normal and not an infective one requires clinical and laboratory investigations" (Dutta 2008: 524).

So while non-Indian textbooks define leukorrhoea as vaginal discharge of any color and due to any cause - infectious or non-infectious - the Indian textbook identifies vaginal discharge as leukorrhoea only if it is of normal composition, in other words if it does not contain viral or bacterial pathogens, and is therefore non-infectious. This definition is reflected in the standard reference for the correlations of ayurvedic with biomedical gynecological diseases, in which *shvetapradara* is defined as "a symptom of all gynecologic disorders developing due to vitiation of *kapha* and *vata-kapha* (...) [and] a condition characterized with white vaginal discharge not associated with pain, burning sensation and discomfort, thus, it seems to be description [sic] of leucorrhoea" (Tewari 2000: 168). Since pain, burning sensation, and discomfort would indicate inflammatory changes due to an infection, this definition of leukorrhoea is in accordance with the Indian textbook quoted above.

When women's fear of white vaginal discharge is likened to the *dhat* syndrome in men, it is this definition the authors refer to, as for example Chaturvedi (1988) does when using the term leukorrhoea and excluding women with gynecological illnesses from his study. It lies in the nature of an illness classified a culture-bound syndrome that its cause is not seen under the microscope, but in the cultural reservoir of ideas relating to body and health of the affected person, so the meaning of the term leukorrhoea as non-infectious vaginal discharge in the context of *dhat* syndrome makes sense. But where the ambiguity reappears is in the context of medical anthropological research not based on laboratory investigations, which uses the term leukorrhoea while coining it as an idiom of distress or communication and cross-referencing to *dhat* syndrome (eg. Nichter 1981 & 2010, and Trollope-Kumar 2001a & 2001b), without being explicit about referring to white vaginal discharge of unconfirmed origin rather than to biomedically unexplained and non-infectious discharge.

I do not mean to say that anthropologists lack microscopes, as I am well aware of anthropology's methodologies and the value of such knowledge acquisition, instead I wish to draw attention to the fact that the Western biomedical doctor's leukorrhea might not be the one of an Indian biomedical doctor, the psychiatrist's leukorrhea of dhat syndrome may not be the anthropologist's leukorrhea of somatic idioms, and what an Indian *vaidya* calls leukorrhea might be an altogether different thing. While such a multilayeredness in meaning is not per se problematic, it can become if the object of a study is not delineated from that of others, but might go under the same name – such a conflation rather than shedding light on a complex phenomenon increases its area of uncertainty and can provide for grave misunderstandings between scholars of different disciplines who build up on each others work.

To avoid such problems of ambiguity and fulfill my part in making explicit the object of my study, I anticipate part of what will be the result of my attempt to approximate what is called *shvetapradara* in ayurvedic practice: I set out to contribute to the discourse of non-infectious vaginal discharge, as it is central to both the notion of a female *dhat* syndrome and that of Indian women's ways of somatizing distress and anxiety. But what I encountered in the ayurvedic hospital was that non-infectious vaginal discharge was neither considered to be common by the *vaidyas*, nor was it practically diagnosed or inferred based on ayurvedic diagnostic criteria. The *vaidyas* did not use microscopes, but were convinced that most commonly if a woman complained of *safed pani*, she had an infection. The word *shvetapradara* was translated by them as leukorrhea, both of which in the *vaidyas'* language denoted an abnormal vaginal discharge of any cause.

3.2 Ayurvedic Practitioners

An element making a frequent appearance in the descriptions of leukorrhea in the South-Asian context is the deep rootedness of Indian notions of dangerous reproductive-fluid loss in ayurvedic thought (for female *dhat* syndrome see Karasz et al. 2007: 488; Trollope-Kumar 2001a: 262 and 2001b; Patel et al. 2008: 261). What is left largely unexplored in the existing studies about *dhat* syndrome and leukorrhea, is the ayurvedic gynecologists' theory and practice regarding the symptomatology of white discharge: Considering the fact that in India's pluralistic

health sector “biomedical concepts compete with traditional views and treatments” (Karasz et al. 2007:477), women with the complaint of leukorrhea come in contact with a broad variety of explanations by different health care providers. Ayurvedic doctors take part in treating white vaginal discharge to a great extent, providing explanatory models and treatment modalities to Indian women, and are (apart from female patients, biomedical gynecological doctors and psychiatrists) an important piece in the puzzle of the discourse about vaginal discharge and its related thought and practice in India - a piece, which has not received due attention in the discourse.

The anthropologist and Medical Doctor Karen Trollope-Kumar not only discusses the ayurvedic theory underlying the fear of losing a precious body fluid (2001a, 2001b), but is one of the few authors addressing the view of Ayurveda practitioners as well:

“Ayurvedic practitioners call this condition [vaginal discharge without clinical evidence of infection] *dhat rog*, and say that it is because of excess humoral heat in the body. (...) When women consult a biomedical practitioner they are often told that this problem is not a disease. Ayurvedic practitioners, however, consider this a serious illness which will lead to progressive weakness if left untreated. (...) The cultural messages of leukorrhea are understandable to Ayurvedic practitioners, who share the same concepts about the body. ” (2001a: 262-263)

The essential distinction Trollope-Kumar does not make, is the one between professional ayurvedic gynecologists and the practitioners belonging to the lay or folk sector of ayurvedic healing, allowing for the all too easy conclusion that ayurvedic physicians generically, and as opposed to the doctors of biomedicine, share the same cultural concepts like their patients complaining of leukorrhea. But Ayurveda, while rightfully described by Kakar (1982) as the principal repository of the Indian cultural image of the body, in its contemporary practice is neither self-contained, nor do all of its practitioners draw upon the same sources of knowledge.

A PhD in ayurvedic gynecology I interviewed during my fieldwork for example, Dr. Sneha⁶, said something quite different from what Trollope-Kumar's informants

⁶ All names have been changed.

state. *Dhat rog* is not a terminology used by her or any other ayurvedic doctors in the university and its hospital I conducted research in, instead white vaginal discharge is called *shvetapradara*. Its occurrence is not attributed to excess humoral heat, but to a vitiation of kapha dosha, which is of cold property. About the seriousness of this condition, Dr. Sneha said:

“The patients are thinking, due to a lot of discharge we are getting weaker, weaker, weaker. They are thinking like this: An essential *dhatu* in the body is going. But nothing is there but discharge due to general debility or previous pathology.”

The argument I wish to bring forward by means of this comparison is not an evaluation of either Trollope-Kumar's informants or their opinions in any way, but to draw attention to the fact that what 'ayurvedic practitioners' say differs greatly depending on the local tradition and educational background they are rooted in, and that a fruitful investigation of contemporary Ayurveda's stance on a particular disease entity has to acknowledge the multiplicity of practiced Ayurveda in India and requires a careful delineation of the informants' backgrounds.

The informants of my research I present in this paper are ayurvedic professional gynecologists practicing and teaching in a government university hospital in North-West India, and the way white discharge is negotiated, diagnosed, and treated in their practice. What I refer to as professional ayurvedic gynecologists are those who studied professional degree courses at Indian universities, who have received the degree of BAMS (Bachelor of Ayurvedic Medicine and Surgery), thereafter their MD and possibly PhD in ayurvedic gynecology, and who are registered medical practitioners at the Board of Ayurvedic and Unani Systems of Medicine in their respective state. This is to differentiate explicitly between practitioners of Ayurveda who are university graduates, rooted in the classical Sanskrit scriptures, and influenced by the paradigm of biomedical scientific research (as I will describe in greater detail in the following chapter), as opposed to those whose practice is certainly based on ayurvedic principles, but generally transmitted informally and draws much more on generational experience than on classical or biomedical reference.

3.3 *The Institutionalization and Professionalization of Ayurveda: Historical Aspects*

The education in India's Ayurveda institutes today is strictly regulated by the Central Council of Indian Medicine (CCIM) under the AYUSH (an acronym for AYurveda, Unani, Siddha, and Homeopathy) department of the Indian Ministry of Health and Family Welfare. The syllabus of the Bachelor of Ayurvedic Medicine and Surgery taught nationwide at 254 undergraduate Ayurveda colleges (Chandra 2011: 70) and the research parameters the *vaidyas* work under in India's 64 ayurvedic postgraduate institutes (ibid) are the result of various political struggles in India during the British colonial rule and disputes between Indian ayurvedic practitioners, and contain - apart from the ayurvedic content - a large amount of biomedical aspects as well. In the following I will give a short outline of these historical developments surrounding the professionalized Ayurveda education having brought forth almost 480,000 registered practitioners active in India today (ibid), as it is in these processes that sociologists, medical historians and anthropologists locate the existing asymmetries between biomedicine and Ayurveda, in the sole light of which the 'syncretism' (Leslie 1976 and 1992) of cosmopolitan medicine and contemporary ayurvedic practice is analyzed until today.

The first educational institution offering a medical degree program spanning both Ayurveda and biomedicine was the in 1822 established Native Medical School in Calcutta (Islam 2010: 778, Sujatha and Abraham 2009: 37). Its establishment was not unrelated to 19th century Orientalists' interest in Indian culture and languages and their idea of "reforms (...) undertaken by utilizing indigenous institutions" (Leslie 1976: 361), but aimed all along at establishing the hegemony of Western medicine by unmasking the insufficiency of traditional medicine (Langford 2002: 5). It was meant to attract practitioners of indigenous systems of medicine, and provide them with the scientific skill to recognize the fallacies of their tradition (Arnold 200: 62-63) and to provide "cheap but reliable medical aid for Company servants" (Arnold 2011: 62). The Native Medical School found its early end in 1835 due to an inquiry ordered by the Governor into its condition and effectiveness (Jaggi 1980: 10). After this "brief period during which an indological interest in classical medicine was allowed to intermingle with the introduction of modern medicine" (Langford 2002: 5), Ayurvedic training was absorbed into

Sanskrit Colleges (Islam 2010: 778-779) and biomedicine soon became the only official state-sponsored system of medicine (Sujatha & Abraham 2009: 37).

Even if the culturally pluralist (Leslie 1976: 361) Orientalists did not succeed with their idea of educational reforms based on existing indigenous infrastructure, their ideology of a golden Indian past in need of a revivalism found sympathizers in Hindu scholars (Leslie 1976: 362), together with whom they framed a theory of decline which “provided the ideological ground for [the] professionalizing reforms” (ibid) stimulated by the Ayurvedic Revival Movement between 1885 and 1947⁷ (Ganesan 2010). This theory of decline (which is still evoked in some contemporary ayurvedic textbooks⁸ and clearly a myth according to Leslie 1992: 195) argues that Buddhist, Muslim, and British invaders of India were responsible for the decay of the advanced Ayurvedic expertise described in the classical scriptures (Leslie 1992: 195), and that Ayurveda, in order to shine as it did in the past, needed to “demonstrate that the institutions and scientific theories of cosmopolitan medicine were anticipated in the ancient texts” (Leslie 1976: 365). Inherent in this demonstration lied the engagement with the episteme of modern medicine, and at the end of the 19th century ayurvedic physicians realized “that in order to combat the increasingly widespread mimicry of European bodily practice, it would be necessary to copy certain forms of European institutional practice” (Langford 2002: 7), so Ayurveda's association with Sanskrit colleges was undone. In the beginning of the 20th century separate educational and research institutes for Ayurveda were founded (Islam 2010: 779, Langford 2002: 6, Leslie 1976: 363 and 1992: 179), which used in their curricula, textbooks, and practice the language and technology of cosmopolitan medicine to reinterpret traditional knowledge (Leslie 1992: 179). The publication of medical textbooks in English correlating ayurvedic with biomedical disease entities and English translations of

⁷ Leslie (1992) does not limit the period of medical revivalism to the time of British colonialism, but describes the 1960s as their closing decade.

⁸ Rao (2002: 7-9) for example writes in his handbook of shalya tantra [surgery]: “If one goes through the Ithihaas [history] of Ayurveda, it can easily be understood that Brain Surgery, Reconstruction surgery, Cataract surgery, Transplantations and implantations, (...) were being conducted by Ayurvedic surgeons right since the vedic period up to the period of Buddhism and later on. (...) Now the questions is how and why such a great science Ayurveda has lost its popularity and fame in the land of its origin. (...) Unfortunately this great nation had to face foreign invasions for the last 12 centuries right from Alexander – Greeks, Pathans, Moghals, and British invasions have not only destroyed and captured our freedom, they have attacked our cultural and intellectual heritage also. (...) The so called English language in India could become almost a national language just because of the British rule on this holy land. The original languages like Sanskrit, Hindi etc. have gone down and the foreign language was forcibly dumped on this land by the Britishers and now we are not able to leave that language and its baseless fashions due to our slavery for centuries together.”

the classical Ayurveda scriptures with new commentaries peaked at the turn of the 19th to the 20th century (Ganesan 2010: 109) and contributed to the aim of medical revivalism. This aim, to “reinterpret and defend Hindu civilization in the light of modern European scientific thought” (Ganesan 2010: 115), matched the endeavors of the nationalist movements and the quest for *swaraj* (self rule), which led to the Indian National Congress's first resolution criticizing the vituperation against indigenous systems of medicine by “laymen antagonists” in 1918 (Chandra 2011).

Starting with the Medical Practitioners Act in Bombay Presidency in 1938, and soon followed by other provinces, medical rights similar to the ones of allopathic doctors were granted to *vaidyas* and their education and registration as medical practitioners was regulated. This regulation was determined only to be available to *vaidyas* who had completed an integrated course at one of the new educational institutes, and therefore excluded *vaidyas* trained in the traditional method of *gurushishyaparampara* (discipleship to a guru) (Langford 2002: 109). It was at this point that two factions of *vaidyas* formed (ibid), which would over the next decades struggle for the implementation of their ideology into the ayurvedic syllabus: One advocating *shuddha* (pure) Ayurveda - the purists in Leslie's words (1992) - and the other in favor of *mishra* (mixed) Ayurveda - the integrationists (ibid), who argued for an Ayurveda education including allopathic topics, as had been propositioned by the 1938 act. To shorten history unduly (albeit by requirement with regards to the scope of this text), the uprising of purists succeeding the abolishment of traditional teaching lineages in 1938 was followed by student protests in the mid 20th century, strongly demanding to be put on par with modern doctors by being granted a modernized syllabus and equal facilities (Langford 2002: 113).

Even though later the tables turned again in favor of the *shuddha* faction (Wolfgram 2009), the syllabus as it exists today is not divided according to different classical scriptures (as a *shuddha* approach would suggest), but is built on a “modern division of subjects” (Langford 2002: 115), and includes not only modern medical theory, such as anatomy and physiology - which is taught side by side with their ayurvedic equivalents - but also dissection, laboratory experiments and a limited range of surgical procedures. Even though one might expect the debate to have settled after many back and fourths in the issue of *shuddha* versus

mishra Ayurveda, a recent survey mandated by AYUSH revealed that “such a wide spectrum of Modern Medicine content has been criticized by many of the persons [graduate-, post graduate students and teaching staff] interviewed” (Chandra 2011: 71).

3.4 Institutionalized Ayurvedic Education and Practice: Today

The above description of events surrounding the institutionalization and professionalization of ayurvedic medicine, despite being far from comprehensive, speaks clearly of a system of medicine which has in its medical and educational theory and practice since long been defined through its biomedical other - even by its purist proponents arguing for the opposite - “continuously answering its critics as well as justifying itself in terms set by its critics” (Ganesan 2010: 117). It is this subordinate position of Ayurveda to biomedicine, established through the above sketched historical developments in colonial and post-colonial times regarding its professionalization and institutionalization, which has dominated the sociological and anthropological discourse about Ayurveda throughout the last decades:

Leslie (1992) for example, even though describing at the example of two influential *vaidyas* of institutionalized Ayurveda how ayurvedic practitioners engage in the dialogue with biomedicine differently - some rejecting the conceptual translation of ayurvedic terminologies into the language of biomedicine and others strongly favoring it – concludes:

“No wonder, then, that modern science can be unsettling when educated Indians realize that it is grounded in a different conception of knowledge than the one that in ritual and daily life forms their sense of reality and truth. And no wonder Ayurvedic physicians (...) reconcile humoral concepts with biomedical knowledge. (...) A way of life is at stake in their interpretation of illness, and not just a set of medical practices.” (204-205).

Leslie portrays the reconciliation of Ayurveda's doctrine of *doshas* with modern medical concepts by ayurvedic physicians or educated Indians as an urgent necessity for their life making sense, when it comes in touch with the Western scientific episteme as well as Indian philosophy's ways of knowing reflected in ritual and traditional medicine. To protect a particular Indian way of life and maintain their cultural identity under the hegemonic influence of modern science

the ayurvedic doctors *have to* reconcile two systems grounded in different ontologies, two incommensurable entities, even if it is just through a “make-shift structure” (Leslie 1992: 195).

Langford (2002), writing about the modernization of India's traditional medicine, depicts contemporary Ayurveda in India as simultaneously modern and in tension with the modern as a result of its “nationalist task of healing wounds of colonialism and post-coloniality” (2002: 263). Since modern modes of knowledge were meaningful to a national modernity, while the tradition of Ayurveda was important to the notion of 'Indian-ness', Ayurveda colleges and research institutes modeled on the examples of Western institutions were founded. Langford sees the devastating results of this mimicry of European institutional practices in the dissonances between form and content “within contemporary Ayurvedic teaching hospitals, where the curriculum and the degrees granted routinely *misrepresent* the educational and knowledge practices of the classrooms and wards” (2002: 98, her emphasis) and connects with these “slippages” (2002: 99) the corrupt state of contemporary Ayurveda education, in which degrees can be bought through rank and money. The “poetic logic” (2002: 116) of ayurvedic Sanskrit scriptures is diametrically opposed to the exposition of facts in the textbooks of cosmopolitan medicine, which further adds to the field of tension and gap between structure and content, as “ayurvedic concepts tend to be confined to the classroom, while biomedical concepts tend to dominate the clinical instruction” (2002: 127). Langford writes of experiencing a “frustrating thinness” (2002: 100) when visiting ayurvedic colleges as an ethnographer, later realizing she had been “seeking complexity in the wrong place” (*ibid*) and could only understand modern ayurvedic education when “view[ing] it no longer as a disassembled or dissembling text, but as an improvisation” (2002: 101).

An ayurvedic educational institution like the one I have come to for the fieldwork this paper is based on, becomes an empty shell in Langford's description, an external framework established in a particular form to be on a par with biomedicine, which does not hold its promise of representing and delivering the appropriate ayurvedic content in education and practice. The degrees awarded by these institutes may allow their holders to practice ayurvedic medicine sanctioned by the government of India, but are - according to Langford's informants – not more than that; they neither represent practical medical competency as they need

to be followed by years of apprenticeship under an experienced *vaidya* outside the institutionalized practice, nor do they reflect excellent academic performance, since they can be obtained through bribery.

Also concerned with the intersection between Ayurveda and biomedicine in modern ayurvedic pedagogy and clinical practice is Naraindas, who speaks of modern Ayurveda as “a kind of mongrel determined by at least a hundred years of shifting curricular history shaped by nationalist politics, colonialism, industrial pharmaceuticals and global science” (Naraindas forthcoming), a traditional system of medicine “mangled if not recast (...) by an asymmetrical conversation with allopathy” (forthcoming). He describes graduates of the BAMS program as “trained in two systems of medicine” (2006: 2662), as medical practitioners who cannot “get away from this hybrid world” (2006: 2667) and have to “manage to straddle (...) two cognitive universes” (2006: 2666). The universe of biomedicine, according to Naraindas, is a “source of comfort and authority” (2006: 2662) for the modern *vaidyas*, many of whom ended up in the ayurvedic degree course because they did not get the much higher valued seat in the bachelor program of modern medicine. Naraindas finds an important indicator for the asymmetrical relationship between Ayurveda and biomedicine in the translations of classical ayurvedic scriptures into English and their recent interpretations, both of which involve a forceful matching of what is ontologically different (ayurvedic and allopathic nosology and terminology), resulting in a loss of the multi layered meaning a single term can have in the ayurvedic universe (2006: 2667).

What characterizes modern ayurvedic doctors' education and clinical practice according to Naraindas is their “linguistic and conceptual bilingualism” (2006: 2667) caused and continuously fostered by translations and interpretations of texts, which “use allopathy as a yardstick” (ibid).

From Naraindas' choice of vocabulary regarding his description of the current state of modern Ayurveda in India emerges a maltreated ('mangled', 'recast', 'forced') system of traditional medicine, which has suffered from the tussle surrounding its institutionalization and professionalization, and had to reconcile with the parameters of its winning rival. Agency does not appear in this portrayal of Ayurveda, it seems to be an entity which does not so much act as it is acted upon – and the actors it brings forth, the modern *vaidyas*, are so much a result of their parent 'mongrel' that they find comfort in the language of who was once their

traditional science's perpetrator and could not, even if they wanted to, eventually undo the bonds with allopathic medicine.

The last author I would like to recap in this context with reference to modern Ayurveda in India is Sujatha (2011), who addresses the fact that despite a considerable amount of laboratory research and innovations at educational and other research institutions funded by the Indian government, Ayurveda and other Indian systems of medicine [ISM] did not experience a cumulative growth through these efforts. Referring to Kuhn's definition of incommensurability⁹, she ascribes this phenomenon to the “conflation of the objects of inquiry and cross-paradigmatic conceptual reference (...) now part of what is called 'evidence-based medicine’” (2011: 298) resulting in the practitioners of Indian systems of medicine (ISM) “straddl[ing] between two aetiological and conceptual systems” (ibid). This bridging of two incommensurable systems which is necessary if an ayurvedic researcher wants to enter the dialogue of modern research at all, “would [ultimately] erode its [ISMs] integrity” (2011: 209, additions by L.G.), as “there is no mutuality in the relation between biomedicine and ISM” (ibid) and therefore an innovation, should it occur, “will be invisible in the sense that it will not have an institutional existence and embodiment” (2011: 208).

Sujatha considers a possible remedy to the expected loss of core aspects of Ayurveda following its long standing exposure to laboratory technology and the biomedical paradigm, the “systematic documentation of clinical efficacy of ISM under lived conditions as a mode of verification” (2011: 209), in other words, the focus on the effect of traditional Indian medications and treatments *in vivo* instead of *in vitro*, as the *vaidyas* and *hakims* of the pre-biomedical past had done for centuries.

The medical research every ayurvedic MD and PhD scholar in India needs to conduct as a fulfillment towards their degree, which contains not uncommonly a conceptual, pharmacognostical, antimicrobial, and clinical study based on both ayurvedic and allopathic parameters and reviews of the object of study, in Sujatha's view proves a fruitless attempt of making commensurable what is not, ultimately leading to a destruction of what is Ayurveda's true essence. The results of ayurvedic research under modern science's parameters has according to

⁹ Sujatha writes (2001:195): “In Kuhn's framework (2000) they [ISMs] are incommensurable in that they have no common measure or neutral language 'into which both theories could be translated without loss' (2000: 36).“

Sujatha no effect on India's medical landscape and its communication between traditional and biomedical doctors, as the *vaidya* - even though he accepts the language of his other - “has little control over the result of the dialogue” (2011: 209) and “will not be taken seriously by biomedical experts” (ibid). Implied in this argument is the assumption that modern ayurvedic scholars conduct their research in the language of cosmopolitan medicine solely to acquire its acceptance or blessing, or to finally become its equal, which in turn assumes the *vaidyas'* perpetuated self perception as subordinates, but excludes the possibility that they themselves in their understanding of truth and reality are interested in conducting such 'hybrid' research. What clearly lacks consideration then is the fact that, as Sujatha herself states, “we have little information on the involvement of 30,000 youngsters who graduate from AYUSH colleges every year” (2011: 207) and not much can be found about the institutional research conducted by more than a thousand ayurvedic post graduate scholars admitted in India each year (Chandra 2011: 70), either.

4 Theoretical Approach

My inquiry into contemporary ayurvedic practice at the example of an ayurvedic gynecology department's negotiation of leukorrhea in daily clinical practice is based on Mol's approximation of a disease through a praxiographic rather than epistemological approach, which she lays out in her work addressing multiplicities in the ontology of medical practice at the example of atherosclerosis (2002). Mol determines that an object – for example a diagnostic entity or the body itself – differs in its identity depending on the site and situation it is enacted in; therefore what runs under a single name is in fact a manifold object, which despite its multiplicity is not fragmented but “hangs together” as “more than one and less than many” (2002). Reality, accordingly, is not singular, and “*ontology* is not the given order of things but (...) instead, *ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practice” (2002: 6, her emphasis). What determines, according to Mol, if an object exists, is its enactment in daily practice and not its theoretical substantiation in a textbook. Having demonstrated the multiplicity of objects in enacted reality that go by the same name, Mol investigates their coordination into an apparent singularity necessary under the “threat of incommensurability” (2002: 85), the latter of which a monistic science would not be able to withstand.

Mol studies the multiplication of an entity and the ways its amalgamation is achieved in her fieldsite (a Dutch hospital) neither by concentrating on patients, nor by means of investigating medical imagery or paperwork, but instead follows the disease at the side of various doctors and contemplates it at multiple sites within one institution, exploring the “fleshy affair” (2002: 27) of daily life and medical practice, looking for medical knowledge in “activities, events, buildings, instruments, procedures” (2002: 32) rather than the expositions of medical professionals.

I have taken on Mol's praxiographic approach and followed a single disease through different sites and contexts within one university hospital, exploring the doctors' practices and academic instructions surrounding it, the materialities involved, both the scope and restrictions defining their practice and subsequently the object enacted. But while Mol studied multiple ontologies within the paradigm of biomedicine, my study focuses on modern ayurvedic education and practice,

which in themselves are the result of an integration of biomedical knowledge into the traditional system of Ayurveda. Furthermore, the object of my study – leukorrhea – gave reason to expect multiplicity from the beginning not only because of the integrated form of Ayurveda practiced at the hospital I would conduct fieldwork in, but also due to its manifold identity in the biomedical, psychiatric, and anthropological discourse.

My aim by using Mol's praxiographic approach is to make known the entities running under the name *shvetapradara* and explore the complex whole thereof – multiple and with frictions, yet not fragmented. Just like Mol I do not aim to present a coherent entity neither in my description of leukorrhea nor in my observations regarding the integration of biomedical concepts into ayurvedic practice - since there is none, as “objects come into being - and disappear - with the practices in which they are manipulated” (Mol 2002: 5). Instead I follow Mol in presenting “sketches of separate scenes (...), snapshots (...) juxtaposed to each other” (Mol 2002: 53) to approximate an object in its specific site and situation.

Accordingly, in my approach to the research topic the labeling of leukorrhea as a disease or illness of either the mind or the body, the defense of either its biomedical or ayurvedic definition, is not of interest. My aim is not to prove or falsify any of the statements made or categories constructed in connection with discussion of the symptomatology of non-infectious leukorrhea, instead I wish to engage with it and explore it in its own right as negotiated in the practice of a contemporary academic ayurvedic government hospital in India, signifying the way in which Ayurveda and biomedicine are intertwined with regards to understanding, diagnosing, and treating a disease.

5 Field, Methodology, and the Challenge to Find a Role

To research if and how biomedicine and Ayurveda meet, intersect, and possibly clash in contemporary professional ayurvedic practice at the example of the symptomatology white discharge per vagina, my field would be the gynecology department of an ayurvedic teaching hospital in India. I decided to draw on my ties to the Ayurveda university and its hospitals where I had obtained my BAMS degree three years earlier, and indeed did my status as an ex-student of the university and that of an accredited *vaidya* allow for an easy access to the field. I got the permission of the director of the institute for postgraduate teaching and research in Ayurveda to spend ten weeks in the university hospital's *Stri Roga* and *Prasuti Tantra* department, to observe the day-to-day medical practice in out- and in-patient departments and to speak with professors, readers, scholars and patients. That I could gain access to a hospital, its gynecology consultation- and examination rooms as well as its surgical theaters as an anthropologist in a relatively uncomplicated manner and did not have to obtain any type of clearance from an ethical instance is probably due to the fact that “unlike Western countries, developing countries in general (...) do not have a strong culture of research and no institutionalized body to regulate the issues of ethics, rights, or privacy issues.” (Zaman 2008: 138).

Even though this circumstance made my entrance to the field one without many hurdles, it did not relieve me of ethical considerations and responsibilities during my fieldwork: I was a daily witness to women's stories of gynecological illness and disease, and the examination of the most intimate parts of their bodies, both of which carry with them insecurities and often a sense of shame. I was always careful to pay utmost attention to the patients' and doctors' needs in any given situation so as to avoid becoming a burden or hindrance to the people involved. In situations where a helping hand was lacking I assisted the doctors in examinations, held patients hands, consoled and reassured them, and corrected their postures on the examination table so the procedure would be less uncomfortable.

In the hustle and bustle of the OPD, when sometimes up to twenty people filled the twelve square meter room and usually four to five consultations were being conducted simultaneously, none of the patients seemed to wonder about my

presence. Since foreigners sometimes come to the hospital for periods of their clinical internship of the BAMS, I was probably assumed to be one of them, even though I did not wear the white coat mandatory for doctors and interneees. In the rare case of a woman looking intimidated or worried by the presence of a foreigner in the much calmer examination room, where apart from medical staff and students only one patient at a time was present, the doctors reassured the patient that I was a doctor, too.

A much greater challenge was the negotiation of my role with Dr. Shreedevi, the head of department and associate professor of the *Stri Roga* and *Prasuti Tantra* department, who had been assigned responsibility for me by her superior, the director of the research institute. Despite her efforts to convey this responsibility on to one of her MD scholars, Dr. Pooja, who had recently completed her research work about the clinical efficacy of a pharmaceutical preparation for *shvetapradara* and was therefore deemed by Dr. Shreedevi to be the perfect contact person for me (“Pooja is your guide now. First, you ask her, she is an expert in *shvetapradara*. Then whatever question is left, you come and ask me.”), Dr. Shreedevi remained the one constantly displaying responsibility for me and my work throughout my stay.

Even though I tried to outline for her the general subject, methodology and scope of medical anthropology and my research topic in this context, my identity for her was that of an ayurvedic doctor generally and of her student particularly: In the OPD she frequently asked me to take patient histories, measure blood-pressure, list the patients' details in the department's register, assist in examinations, write prescriptions, and perform ante-natal check-ups on pregnant women (“You should learn, no?”). She noticed me sitting around observing and taking notes, but withdrawing from taking cases – after all, I wanted to focus on *their* medical practice, not mine – with dissatisfaction (“When will you start your work?”), was concerned about the nature of my research (“So, are you doing a conceptional study or a clinical study?”), and reprimanded me when I stayed away for a day to work on my field notes (“Where were you? Why you were not here yesterday?”). Despite me reassuring her repeatedly that I was in line with anthropological research methods in what I was doing, that I didn't need the timetable with fixed attendance times which Dr. Shreedevi issued for me, and that my German university trusted me to be responsible enough to conduct efficient research, my

work and the apparent freedom that comes with it remained unsettling for her. In a final letter she issued for my university, Dr. Shreedevi wrote “I am fully satisfied with her [Linde's] work”, but not without saying teasingly to me: “Should I tell your professor you were roaming here and there?”.

Participant Observation, the “foundation of anthropological research” (Bernard 1988: 148), poses a particular challenge when researching doctors in a hospital setting, as the anthropologist who doesn't want to pose as a patient has to find a way to take part in the daily activities of the hospital without engaging in medical practice, has to assume a social role which allows for more than an outsider's observation of others' practices, but for an actual participation. In my case, to participate as a *vaidya* would not have been impossible, since I am a registered medical practitioner in India and was asked by professors as well as scholars to take on the tasks of a doctor, like I had learned and done during my education a few years earlier. But I feared, had I taken on the fullest level of participation available to me (to work as a *vaidya* in consultation, examination, and treatment), that I would have lost the ability to differentiate between my own practice and the one of others, between my own way of ayurvedic reasoning and the one of others, ultimately leading to a mingling I would not have been able to intellectualize once I removed myself from cultural immersion (Bernard 1988: 148) in a project limited as this.

So while I sometimes accepted the doctor's role in the clinical settings to establish rapport with the patients and physicians around me, and to show interest and active involvement in “a common goal, a plot, an emerging narrative” (Wind 2008: 85) as was expected of me as their fellow *vaidya*, I generally tried to remain clear to myself and others in thought and action that I was there as a researcher of another discipline, since to “behav[e] as if the ethnographer is bound by the same ties as staff/patients, is to misconstrue the role of ethnographer” (ibid).

Whereas this strategy allowed me to take part in situations in the hospital while still finding opportunities to take down notes during fieldwork and follow particular cases through various days, rooms, and instances (which would have never been possible had I assumed the doctor role more often), it proved to be a hindrance in the semi-structured in-depth interviews I conducted and recorded with different *vaidyas* during my fieldwork:

I intended to stick to the role of the anthropologist interviewer facilitating and stimulating narratives and statements while keeping the chances of reactivity as low as possible. To avoid falling into the trap of overseeing structures, behaviors and particular dynamics of argumentation just because they are familiar to me and integral to my ayurvedic way of thinking, I didn't exclude basic questions about ayurvedic physiology related to my research topic in my interview guide. But as I had to realize interviewing Dr. Shreedevi, that role was not granted to me, and even when I accepted what she deemed suitable for me in this situation - the role of an ayurvedic student - it was more difficult to get answers than I had anticipated.

[Asking about the *lakshana* [signs and symptoms] of decreased *rasa dhatu* [roughly translatable as lymph, one of the body tissues affected in cases of *shvetapradara* observable in and by the patient]

L: And the *lakshana of rasa dhatu kshaya* [decrease of *rasa dhatu*], how do they show in the patient?

Dr. S: So what is the *rasa dhatu kshaya*? You have read five years, you just tell! You just tell what is the signs and symptoms of *rasa dhatu kshaya*!

L: When it comes to classics, I know. But is it same in your clinical experience?

Dr. S: First of all you tell, then I.

L: *Rasa kshaya* means inability to bear noise, and light, the *indriyas* [sense organs] get very weak, so if a person is screaming, there is loud noise, they [people with *rasa kshaya*] cannot tolerate it. Then, loss of appetite, then I think dryness in the mouth is there, *mukhashosha*...is it correct?

Dr. S: You tell!

L: *rasa kshaya lakshana*...then, irritability I think.

Dr. S: You are absolutely correct what you are telling, you are just correct.

L: And practically you see that in the patient, or generally not so much?

Dr. S: I have not done an in-depth study of this.

After several of such encounters I decided to meet my interview partners ayurvedically on equal footing, as Bernard (1988: 158) writes:

“The role of naïve novice is not always the best to play: Humility is inappropriate when you are dealing with a culture whose members stand a lot to lose by your incompetence. (...) There are situations where your expertise is just what's required to build rapport.”

The moment I accepted that my interview partners had a very definite idea of what my knowledge as a *vaidya* should encompass, and that my level of ayurvedic competence reflected the quality of education at their very own institution, the common ground of our interview was set and communication became easier.

[in the next meeting with Dr. Shreedevi, discussing the concept of *shukra dhatu* ('semen', reproductive fluid) in women]

L: All of the human beings have *sapta dhatu* [seven *dhatu*s], so *shukra dhatu* is present in both male and female. I read Tewari [a comprehensive textbook on ayurvedic gynecology in English and Hindi], she has given a chapter about *stri shukra* ['female semen']. So what is your opinion, what is *shukra dhatu* in women?

Dr. S: Just I am asking, is estrogen and progesterone present in male? Or not? What is your opinion?

L: Testosterone is also present in women, but in less concentration. Then-

Dr. S: If it is so-

L: In male it [estrogen and progesterone] is there, but in little quantity.

Dr. S: If testosterone is present [in women], then what about the *stri shukra*? Why not?

L: So *stri shukra* is all of the hormones or –

Dr. S: [nods] When it is local, then it is *artava* [ovum or menstrual blood], but when it is the whole body it is the?

L: Hormones.

Dr. S: The hormones. Now you are clear? Any more questions?

What remains to be addressed in this attempt of self reflexivity is the question of *where* I conducted my research and *who* I was in that location: Did I do anthropology 'at home' or 'abroad'? Did I study the 'exotic other' located in a

culture far away from mine or did I study my own kind? In a way the answer is both.

What is in Zaman's terms (2008: 135) a twofold nativity (“a Bangladeshi doing fieldwork in the country, and [...] a medical doctor studying a hospital”), I would describe in my case as a partial nativity, or, better, a twofold identity: Having lived, studied, and practiced Ayurveda in India for more than seven years between 2002 and 2010 has certainly not made me an Indian, and surely my flight from Germany to India led me abroad, away from the country and culture I am native to and identify with - but nevertheless I was an ayurvedic doctor studying the doctors and their practice in an ayurvedic hospital. What makes this setting even more 'at home' is the fact that the university and its hospital I conducted research in is my ayurvedic alma mater, that my way of thinking, arguing, and treating as a *vaidya* is an outcome of that institute's practice and school of thought¹⁰. While it indeed required a great effort to “recreate distance from objects that are existentially familiar”, as Faizang (1998: 275) deems necessary when one conducts medical anthropological research at home, I would not agree with her that “maybe if one is to do research in medical anthropology, it is better *not* to be a doctor” (ibid, her emphasis). Knowing what to expect with regards to the bureaucracy, general procedures and working times of the hospital, the material conditions and hierarchical structures inherent in an Indian government hospital from my time as a student and doctor-in-training at that institution, facilitated my entry the fieldwork site and efficiency in doing research. To have as a common base with the *vaidyas* I worked with during my fieldwork the BAMS education and clinical experience in just their hospital enabled me to integrate quickly into the daily proceedings and “to act so that people go about their business as usual when [I] show[ed] up” (Bernard 1988: 148). To understand biomedical as well as Sanskrit terminologies the doctors used, to know which primary and secondary literary sources they drew upon, and comprehend the choice of drugs they prescribed based on their ayurvedic properties helped me immensely to focus on what I was there for, instead of having to struggle with a medical and cultural subject unfamiliar to me.

¹⁰ The professional education in Ayurveda, despite following a nation wide syllabus, varies in its instructions of clinical application and use of arguments derived from research conducted in case of post graduate institutions. In the southern most states of India, Kerala and Tamil Nadu, for example, *rasa* (metal and mineral) preparations are only rarely prescribed to patients, whereas they are routinely used in North Indian hospitals.

To not let my anthropological vision get clouded by this familiarity of thought and circumstances I maintained a constant habit of self reflexion and “disengage[ment] from medical categories” (Faizang (1998: 275) during my fieldwork, and tried to perceive what surrounded me as novelty and with the eyes of a stranger fascinated to discover exotic territory.

6 The Consultation: Prakrti?

Around the table in the consultation room sit from nine to twelve thirty on Monday through Saturday mornings Dr. Shreedevi, professor and head of the department with 23 years of clinical experience, or on alternating days Dr. Shoba, reader and a practicing ayurvedic gynecologist since 13 years, three to four MD scholars, and sometimes a PhD scholar and one or two students in the internship of their BAMS program. The patients who earlier sat orderly on the corridor waiting for the doctors to come are now shoving towards the desk, as they grow impatient that their name has not been called yet and rightly assume that their presence is more likely turn a doctor's attention to them as their case papers stacked on the desk, which by now have lost their initial order.

Newly arriving patients shove from behind to hand in their case sheets, babies cry, mobile phones ring, the fan under the ceiling turns slowly without stirring much of a breeze, pregnant women exhaustedly make their way to the examination cot in one corner of the room, patients and doctors heading for the examination room next door push their way out from the other, the repeated and impatient striking of a hotel reception bell accompanies the doctors' calls for the next patient when a consultation is over. Now and then one of the doctors tries to establish an order, calls out for the patients to "Please sit down outside! We will call your name when it's your turn!", which is when the women turn quiet, back away from the desk a few inches - and the usual hustle and bustle resumes.

The patient whose turn it is sits down on a steel stool standing behind the consulting doctor's chair which faces the desk, the *vaidya* turns side-wise as much as the restricted space allows him to and starts the consultation with the question "*Shu taklif chhe, ben?* [Guj: What is the problem, sister ?]".

H: I have pain in my hands and legs. When I go for the bathroom, I have some white (*safed*) and sticky discharge. It is not too dark in color. When I go for the bathroom, it is coming out. It is sticky.

Dr. A: Anything else?

H: I feel weak (*ashakti*), then I feel too hot (*garmi*) and I sweat, and I feel giddy (*chakar*). I feel all this when I am out in the sunlight . So my child's father told me

to visit a doctor, if these problems are due to the white discharge (*safed pani*). Due to this white discharge he told me that I feel weak (*nabalai*).

Dr. A: Do you have itching down there?

H: No, no itching, only sometimes. Whenever I feel hot, I take bath, then there is no itching. Only my legs, hands and back are paining. In the back it is a lot of pain.

Dr. A: Where in the back is it paining?

H: On this side [points towards right lumbar area]. Here in the right side. I fell down one and a half months ago – is the back pain due to this fall?

Dr. A: [remains silent]

H: Only on one side there is pain. While I am bending down [doing any work], wet-wiping the floor or if I am sitting for washing the clothes, I can't even wash one bucket of clothes. This type of back pain I have. Does my back pain due to an injury or due to the white discharge?

Dr. A: When did the menses come last?

H: I have a handicapped girl (*apang bebi*) and a boy of three years but now I can't conceive (*balak rahetu nathi*). My girl is handicapped and I have a boy.

Dr. A: For how many days do your menses come?

H: 30 days. I had my last menses on the 30th of April, now count, today is the 14th [of May], so ten days ago.

Dr. A: I mean for how many days do your menses come?

H: Every month for three to four days.

Dr. A: For four to five days?

H: For three days, on the fourth day it gets less.

Dr. A: How many pads do you use per day?

H: I don't use pads, not too many pads. [Dr. A notes down 1/day]

Dr. A: Do you have pain during menses?

H: I have lower abdominal pain before my menses come. I feel like someone is cutting me (*kok kapi nakhe evu duhke*) [cutting pain].

Dr. A: How many children do you have?

H: One handicapped girl and a boy.

Dr. A: Did you have any abortions?

H: One baby girl is handicapped and other two boys are there. [Dr. A writes down A0]

Dr. A: How many years of age are they?

H: The small boy is 3 and half years old and the big is 6 years old and the girl is handicapped (*viklang*) and she is eight years old and she is older than these two.

Dr. A: All the *deliveries*¹¹ were normal or not?

H: *Hospital* and *normal*, but my girl had a forceps (*chipiya*) delivery, she got injured due to the forceps so she has this problem. The doctors said these things to us. But I didn't have a *cesarean*. My middle child was born at home.

Dr. A: Have you done *operation* [tubal ligation]?

H: No.

Dr. A: Are you using any contraception (*sadhan*)?

H: No. We use nothing. We never use anything. After I had my small boy we used condoms (*nirodh*) for five to six months, but now for the last 2 years we are using nothing. But still we have no child. My girl has a problem so we want another girl. I have two boys, but my girl has this problem.

Dr. A: That is enough. Now you have to get the *operation* done. Already you have three children, now how many more do you want?

Dr L: Do you sleep well?

H: Yes, whenever I sleep, it is too much.

Dr A: Do you have too much sleep?

H: I don't sleep in the noon, but at night whenever I go to bed, I can sleep. Even at 9 pm I can sleep. I can't get up early in the morning, not even at 8 am. I can't get up. I can't get rid of my sleepiness early. Sometimes I cannot sleep due to the pain.

Dr. A: Does it burn when you urinate?

¹¹ English words in italics in this interview were used as such while the rest of the consultation took place in Gujarati.

H: Yes, it does. I can't expose myself to sunlight. If I don't wash myself with water after urinating I can't sleep, then I have burning micturition.

Dr. A: Is your hunger normal?

H: Yes, my hunger is normal.

Dr. A: Are you constipated?

H: No. It is not like that. When I expose myself to sunlight, I get burning micturition.

Dr. N [teacher]: Do you not have itching?

H: No, if I don't wash myself after urinating then it gets itchy.

Dr. N: If you clean yourself then you have no itching? Otherwise you have itching?

H: [nods]

Dr. N [to students]: Itching is compulsory in this [suspecting an infection].

Dr. A [to patient]: Go to the bathroom.

[Patient goes to the bathroom to wash herself and comes back for the examination]

Gynecological case taking in the *Stri Roga* and *Prasuti Tantra* department of the ayurvedic hospital I conducted field work in follows a particular protocol, a basic and fixed set of questions, which may be enlarged and sometimes slightly varied in the order they are asked in according to the presenting complaint, but are to be recorded on every woman's case sheet¹². Even though the consultations are conducted in Gujarati or Hindi, the patient's history is noted down on the case sheet in English, and the diagnosis and prescription in Sanskrit. Hamsaben's complaint of "*safed pani pade chhe*" [Guj., lit. "white water is falling/coming out"], is thus recorded by Dr. A. as "white discharge" and diagnosed as "*shvetapradara*".

The protocol of taking cases in the *Stri Roga* and *Prasuti Tantra* department's out-patient department closely follows what I have observed on (irregular) study visits to various allopathic gynecologists during my time as a student in India, with the only difference of the "personal history" (appetite, sleep, stool, and urine), out of which modern doctors only address urination, but leave out sleep, appetite, and

¹² A foto of a case sheet, and a detailed explanation of the questions and the way the case sheet is written can be found in the appendix.

stool. In fact, it is not much more that would reveal this to be an ayurvedic consultation.

When Hamsaben proposes her *safed pani* might occur due to exposure to heat and asks if it could be the cause for subsequent back pain, the *vaidya* ignores those aspects and goes on with the protocol of questions, even though it is those correlations often attributed to Ayurveda in writings about leukorrhea as a somatized psychological complaint (Karasz 2007: 488; Trollope-Kumar 2001a: 262; Patel et al. 2008: 261). That these attributions may well be part of the lay population's or traditional healers' idea of Ayurveda, but not of the professionalized Ayurveda doctors, becomes evident from what I hear repeatedly from my informants: *shvetapradara* occurs due to a morbidly increased kapha and vata dosha, both of which are of cold property, so heating substances, instead of being responsible for white discharge, are in fact used in its treatment. Dr. Sneha, one of my informants, tells me that in her practice she has encountered many patients who hold *safed pani* to be responsible for causing body aches and weakness due to an essential *dhatu* loss, but this is a false conclusion. Of course would the education of the patients help to dispel these myths, but the hectic schedule of an OPD morning does not allow for much interaction with the patient.

Apart from these ayurvedic details of *shvetapradara*, the most substantial theory underlying ayurvedic philosophy, diagnosis, and treatment, the concept of the three *doshas*, makes no appearance in the ayurvedic gynecological consultation. The diagnosis of the patient's *prakrti* (constitution made up of a distinct combination of the three *doshas*) and *vikrti* (imbalance of *doshas*, which disturbs the body and create diseases) are two cornerstones of an ayurvedic diagnosis¹³. Whereas the aspect of *vikrti* is implicitly contained in the diagnosis the *vaidyas* reach to – *shvetapradara* for example implies a vitiation of *kapha* and *vata doshas* – *prakrti* is neither pronounced nor implied in any other category.

Even though I have witnessed *prakrti* being diagnosed as part of consultations in some other departments during my years as a BAMS student and internee of hospital J, it is not a regular occurrence. I remember being surprised when I noticed that something occupying such a central position in ayurvedic thought and syllabus like the concept of *prakrti* did not appear much in clinical practice, and irritatedly asking one of my teachers in the OPD, where the *doshas* were in all of

¹³ see for example Charaka Samhita, Vimanasthanam 8 and Shastri 2002

this, and if we, as *vaidyas*, were not supposed to determine and consider the patient's *prakrti*. My teacher answered that after many years of practice, a *vaidya* develops the skill of intrinsically grasping the *prakrti* of the patient sitting in front of him, which flows into his prescription writing automatically and does not necessarily need to be made explicit - especially not so under the time-pressure of the OPD.

When addressing *prakrti* in my conversations with the ayurvedic doctors, be it students or teachers, they all confirmed the clinical importance of *prakrti* and attributed its absence from the OPD to the working conditions of the hospital, where a high number of patients had to be tended to in a relatively short time. To access someone's *prakrti* would require a detailed engagement with the patient, her physical and mental characteristics, her habits and health history, an engagement no one has the time for on days where twenty to thirty patients per hour are dealt with in one OPD.

Prakrti, even though rarely granted specific mention in the daily practice of the hospital, is still a concept central to its *vaidyas'* thinking as it plays an important role in the prescription of medicines, patient compliance, pathological processes, as well as the ayurvedic education of the public, as I was told by the ayurvedic doctors. Dr. Jalpa, a doctor of the department, talks about her dreams to open her own clinic later in life, so she can practice within her own definitions of what Ayurveda really is:

“If we want to *really* treat the patients with our Ayurvedic approach, at that time we require a lot of change. In the way we prescribe medicines also. (...) I want my own clinic. Here [in the OPD] we say one word, take this, this, this, but in my own clinic I will explain elaboratively, then we will get the result within a few months. In our OPD it takes six months, one year – the patients are running and running [coming back to the hospital for more medicines], because whatever we tell to the patients they are not doing. But if I have my own clinic, then I give more time to each and every patient, I tell them you are such a type of *prakrti*, follow this dietary restriction and take that medicine. Here in the OPD we have just five minutes. (...) We have to compromise. ”

According to Dr. Jalpa, a true ayurvedic approach requires time enough to explain to each patient his or her *prakrti* and the prescriptions based thereon, which would

lead to an improved patient compliance and a higher success of treatments. For Dr. Mahinda, a PhD scholar from Kerala, *prakrti* is especially important for the assessment of the patients' inclination towards particular diseases favored by their constitution. When talking about white vaginal discharge according to Ayurveda and its differentiation into subtypes, he explains how different types of *prakrti* can all favor the development of white discharge per vagina, which occurs due to a decrease of *dhatu*s:

“Because of *dhatu kshaya* [a decrease in bodily tissues], there will be white discharge. So if that is the condition, then we have to think of a few conditions which could cause *rakta kshaya* [a decrease in blood] or *rasa kshaya* [a decrease in lymph] . A patient with *rasa kshaya* will say, 'I get giddiness, I am getting too much angry, I am getting pain in the lower limbs or cramps in the calf region, headaches, and night sweatings'. And if the patient happens to be *vata prakrti* or *vata-pitta prakrti*, then there will definitely be *dhatu kshaya*. And otherwise, if the patient is *kapha prakrti*, and she is indulging in excessive *kaphakara nidanam* [causes that increase *kapha dosha*], then also there would be white discharge, which we call *shleshmaki yonivyapada*, and which has to be differentiated from *shvetapradara*.”

In accordance with what Dr. Mahinda says, to find out which *prakrti* a patient has would help the *vaidya* to reach a more detailed understanding of the factors responsible for her vaginal discharge and even to arrive at a more exact diagnosis. But even though there is no time in the OPD to go into details of *prakrti*, and often *shvetapradara* out of the same reason has to function as an umbrella term for many other gynecological diseases mentioned in the classical scriptures (which have white discharge as a symptom, but are a different disease), Dr. Mahinda is not too worried about how this effects his treatment:

“Why we can't diagnose is not a question. We can diagnose, we can diagnose anywhere. Any type of diseases which are told in the textbook can be diagnosed. But the thing is that we usually (...) neglect it under the heading of something else. But whatever we do, the line of treatment of that is same: (...) [It addresses] either *samsargaja lakshana* [the signs and symptoms of two *doshas* involved in the disease], *ekadoshaja* [of one *dosha*] or *sannipataja lakshana* [the signs and symptoms of three *doshas* combined]. So we are

seldom worried about the diagnosing – is it *shvetapradara*, is it *shlaishmik*, is it *acharana*, or is it *vamini* [different diseases of the female reproductive tract]? We are not worried.”

Even though Dr. Mahinda considers *prakrti* an important role in the predisposition to and causation of *shvetapradara*, he bases his treatment decisions in the OPD primarily on *vikrti*, which allows him to treat successfully even in the absence of a detailed diagnosis and under time pressure. That *prakrti* is anyhow indispensable for any type of engagement with Ayurveda surfaces in the end of our talk, when Dr. Mahinda advises me how to go about working medically with Ayurveda in the West, how to “contribute socially, and create awareness about what you are working on”, despite not being recognized as a physician in Germany. He considers suitable:

“Diet chart, exercise, way of life. For *vata prakrti*, for *pitta prakrti*, for *kapha prakrti*. 'How to know your *prakrti*', make a chart. So if you want to create awareness in the public, make a chart in whatever language they [the people] can understand. If you have these features, then you are *vata* and so on. Then go for consulting. You may not mention medicines because it is only on prescription of doctor, but they can modify diet and lifestyle, and the sexual life behavior likewise.”

Government Ayurveda hospitals providing free health care to hundreds of people every day are in their organization and structure modeled after biomedical institutions, and more often than not it seems as if - apart from the purely ayurvedic medicines prescribed - other peculiarities of this system of medicine have faded into the background in daily practice. The *vaidyas* faced with enormous numbers of patients and material and infrastructural restrictions work under time-pressure and are themselves critical and aware of how such conditions compromise ayurvedic practice not only with regards to what is described in the classical scriptures, but even more importantly regarding what *they* consider an appropriate application of their traditional science in today's time to yield the optimum clinical results. The *vaidyas* I met during my fieldwork have found practical solutions to function within the framework of a government Ayurveda hospital with all the limitations it imposes on them, while not letting ayurvedic ways of thinking, diagnosing and treating slip out of sight. Despite the

compromises they have to deal with in their ayurvedic practice in hospital J, they are confident about what Ayurveda has to give.

Dr. Jalpa, dreaming of her own ayurvedic clinic in the near future, in which she will be able to practice Ayurveda as she personally thinks it should be, do “cultures of discharge (...) [to] have a better idea if it is totally non-infected” and “give more importance to the diet”, talks about ayurvedic gynecology:

“Generally, we say in gynecology we have a lot of work to do. We have a lot of scope. We give from the ayurvedic side to the modern side. Because they have only hormonal treatments, they have only surgical treatments, but they can't [achieve] with their treatment whatever they want. They give supplements from outside. [For example] They can't increase the work of the ovaries. Whatever drugs we are giving, they *can* increase the function of the ovaries.”

7 The Examination & Prescription: Ayurvedic Antibiotics

On the table in the examination room of the *Stri Roga* and *Prasuti Tantra* department lies Manjuben. Thirtyeight years old and a mother of two children, she has come to see the ayurvedic gynecologists for *safed pani*, burning micturition, and painful coitus. Dr. Shreedevi and Dr. Jyoti, a final year MD scholar, enter the small room which is insufficiently lit with the daylight blocked by a wall just a meter in front of the the room's window. While the *vaidyas* put on gloves for the examination, they advise Manjuben to “come down, come further down on the table” and to pull her legs towards her chest with her hands – in that way assuming a position suitable for the per-speculum examination. A floor lamp with a shade in the size of a desk lamp is switched on and throws a yellow light on the body part to be examined. Dr. Shreedevi takes the instruments from a tray and introduces speculum and vaginal wall retractor, while Manjuben clenches her teeth. Dr. Shreedevi asks Dr. Jyoti and me to come closer and have a look, so we all squeeze between wall, lamp and patient, bending down to catch a look while the radiating heat of the light bulb instantaneously increases the sweat on our foreheads. Dr. Shreedevi explains: “White discharge, mild vulvitis and considerable vaginitis present, cervix cannot be seen, maybe due to vaginal hysterectomy”. The instruments are taken out of the patient and placed in the sink,

Manjuben is informed that the examination is over and asked to get up from the table.

While she picks up her pants, which she had earlier let drop down to the stained tile floor and shoved hastily under the examination table with the tip of her feet as if they are both dirty and a nuisance, the doctors strip off their disposable surgical gloves into the sink, so the sister may later place them in the hot water autoclave, boil them, dry them, powder them, role them up and again neatly place them on their tray in the examination room. Doctoral hands and forearms are lathered in red Lifebuoy soap, the rinsing water gives the gloves in the sink a convenient prewash and a reddish color (if they don't already have one), and the thick *khadi*¹⁴ towel hanging on a nail in the wooden window frame probably never needs washing because only clean hands touch it. The doctors return to the consultation room and ask the patient to follow them, pushing through the women still awaiting their turn they reach their respective chairs and benches.

I use the opportunity to talk to Dr. Shreedevi as we walk back into the consultation room.

L: So what do you diagnose?

Dr. S: White discharge is there.

L: Yes, but what does it tell you?

Dr. S: ? [quizzical look]

L: Of what kind was the discharge?

Dr. S: Thick and profuse.

L: So is it an infection?

Dr. S: We don't know, for that we would need a microscope.

L: So how do you treat?

Dr. S: The usual, *ashoka*, *lodhra*, *pushyanuga* [prescribed for all types of vaginal discharge in this hospital]. And *chandraprabha* [an ayurvedic pill].

The case sheet of Manjuben has been waiting under a paper weight on the desk, now it is pulled out from underneath it, and the results of the examination and the treatment are noted down. In cases of *shvetapradara*, the diagnosis Manjuben

¹⁴ coarsely spun cotton

receives this morning, typically a combination of a few powders for oral intake, a coarse powder for preparing a medicated douche and another for making a decoction to be drunk before meals, an oil for local application, and a tablet called *chandraprabhavati* are prescribed.

Whenever I ask Dr. Shreedevi for more details regarding the prescriptions, I get the impression my questions are uncomfortable, sometimes even annoying for her. She often answers that I “should know these things”; that I am now here in light of a different science, one interested in her reasoning rather than textbook knowledge as I tell her, does not seem to matter much. One thing I do hear often from the *vaidyas* around me, though, is that the tablet *chandraprabhavati* is an “ayurvedic antibiotic”, and when I notice that this tablet is prescribed to almost all women diagnosed with *shvetapradara* during the time of my fieldwork, my attention is caught.

While other medications are usually described in ayurvedic terminology (eg. as *sthambanam* [stopping the flow/discharge]), the most important property of *chandraprabhavati* in the *vaidyas'* discourse seemed to be its antibiotic effect – surprising in the absence of any laboratory investigations, which alone could refute or confirm the presence of bacteria and therefore decide over the need of antibiotics, ayurvedic or allopathic ones.

Of course does India's medical staff in rural areas often have to rely on the symptomatic approach of reproductive tract infections, in which health workers prescribe antibiotics based on what they can elicit verbally from their patients in the absence of laboratory equipment and examination facilities (WHO 2007). But scriptural Ayurveda does not have the concepts of bacteria and antibiotics, so the question arises why the *vaidyas* refer to it even if the related examination tools and laboratories are not available, and they would have ways to explain and treat the presenting complaint from within their own paradigm.

Since Dr. Shreedevi has selected Dr. Pooja as my guide in all matters *shvetapradara*, with whom I should discuss all my doubts and questions, I meet her and her colleague Dr. Preethi - both MD scholars in *Stri Roga* and *Prasuti Tantra* in their final year - in a seminar room in the new academic block next to the hospital, an impressive and spacious six story building with a facade of bluish tinted glass windows and elevators from a German company. Both scholars have

recently submitted their theses and are now in preparation for the final defense of their research. They are on department duty, so they do not have to be in the hospital this week, but spend their time in the department's small reading room or the more airy seminar hall to study.

I ask them for the reasons behind the prescriptions for women suffering from *shvetapradara* in the routine OPD practice, and Dr. Preethi explains:

“All the drugs prescribed for *shvetapradara* possess *tikta* and *kashaya rasa* [bitter and astringent properties], which will cause *stambhanam* [constriction of channels, stoppage of flow] and *amapachanam* [digestion of undigested, toxic material, one of the causes of white vaginal discharge]. *Chandraprabhavati* is not only *tikta* and *kashaya* [bitter and astringent], but also antibacterial and antimicrobial. It is routinely prescribed as a treatment [for] and precaution against a possible infection, which can not be ruled out, since a microscopic examination is normally not done.”

An infection can indeed not be ruled out without a routine use of microscopic slides, but - so Dr. Pooja tells me - it can be assumed to most likely be present: In the course of her research she had gotten funding to prepare and microscopically examine vaginal smears of 100 women, who complained of *safed pani* and agreed to participate in her study. The results showed that *all* of the women who complained about excessive white vaginal discharge, had in fact one or the other type of reproductive tract infection, typically a mixed infection of gram negative bacteria and fungal spores. “Nowadays we identify pathogens, at that time [in the time of the scriptures] only white discharge”, says Dr. Pooja.

In light of Dr. Pooja's research it makes only sense, that almost all women with excessive vaginal discharge are prescribed the “antibacterial and antimicrobial” *chandraprabhavati*, which can found in the 13th century text *Sharangadharasamhita*, and consists of 35 ingredients, out of which 29 are of herbal and the remaining ones of metal and mineral origin. The Sanskrit verses concerned with the effects of *chandraprabhavati*¹⁵ say it cures all diseases, is especially useful in all types of urinary disorders, and - just to mention a few – is indicated in anemia, painful menstruation in women, vitiation of semen in men, loss of appetite and decreased digestive fire. It is said to decrease all three

¹⁵ Sharangadhara Samhita, Madhyamakhanda 7, 40-49

doshas, to promote strength, and to have an aphrodisiac (*vrishya*) and a rejuvenating (*rasayana*) effect.

Again I turn to Dr. Shreedevi to hear more about *chandraprabhavati*, and this time she refers me to Dr. Mahinda, a *Stri Roga* and *Prasuti Tantra* PhD scholar from Kerala: "Ask him, he will tell nicely".

I don't see Dr. Mahinda as regularly as the other scholars, but whenever he does enter the OPD consultation room he exudes a calm concentration amidst the noisy activities of the morning hours. The MD scholars - who call him Sir - offer him a seat immediately, Dr. Mahinda sits down and tends to the patients with total attention. I am told by other scholars that Dr. Mahinda knows both modern medicine and Ayurveda very well, and so I meet him one afternoon on the floor of the Shalya Tantra [surgery] ward in the hospital, where he has a small office. Outside, patients sit on wooden benches waiting their turn to enter the adjoining ano-rectal treatment room, inside the fan rotates on high speed making the door curtain, which separates us from the corridor, flutter, and Dr. Mahinda's soft spoken voice can only be understood with the utmost concentration.

Dr. M: It is a *rasayana* also! It is not an antibiotic only. Though it is a broad spectrum antibiotic, it has a broad spectrum according to the *anupanam* [substance taken along with the medicine, is said to augment the action of it] we give, but still it has a *rasayana* dravya [a rejuvenating substance] which is added to it, that is shilajit [bitumen]. It's a *rasayana dravya*! So if *agnimandya* [reduced digestive power] is there, *chandraprabha* you are giving, one thing. The other thing in urinary infection, you are giving *chandraprabha*. There is nutritional deficiency, *agnimandya* resulting, so that will also be corrected. Urinary tract infection will also be corrected, white discharge per vagina is occurring because of some *shlaishmika vikara* [diseases due to vitiated *kapha dosha*], then that will also be corrected, so multiple site of action is there for the *chandraprabha*. Whereas antibiotics they have only particular site of action, throughout the body they will circulate, where there is infection they will subside it, that is the only thing. They don't produce *dhatu pushti* [nourishment of the body tissues]. Antibiotics never produce *dhatu pushti* – they produce *dhatu kshaya* [decrease/destruction of body tissues]. That is the difference between the ayurvedic treatment and the modern. Modern just aims at the germs, and it

kills them. Then it produces an environment which is favorable. Then we have to give the supplementary diet and maintain it. Ayurveda is not so: It produces the homogeneous environment first, so that the toxic materials are expelled by the nature itself. The body tries to expel the toxic materials by itself.”

In Dr. Mahinda's explanation *chandraprabhavati* is such an important medicine in contemporary ayurvedic gynecological practice not only because of the fact that it is a “broad-spectrum antibiotic”, but also due to its additional properties when compared to “modern” antibiotics: It is, mainly because of its ingredient of natural bitumen (a pitch), a *rasayana* dravya: a medicine to prevent old age and prolong life. The etymology of the word *rasayana* reveals the supposed mechanism behind this rejuvenating effect in ayurvedic thought: *rasa* denotes the first of the seven *dhatu*s [tissues of the body] and *ayana* means “coming” or “approaching”. *Rasayana*, literally “the coming of *rasa*” refers to the ayurvedic theory of metabolism, which says that the seven tissues of the body get subsequently nourished¹⁶, one by what is left from the preceding other, via the products of digestion which are transported through an infinite number of minute *srotas* [bodily channels of transportation]. If this transportation of nourishment from *dhatu* to *dhatu* is blocked, by for example undigested food metabolite due to a hampered digestive fire, the individual develops diseases and subsequently his life-span is reduced. In a young and healthy person with a strong digestive fire, *rasa* is “coming” - in a sense of moving, circulating, being transported - without being blocked, and all *dhatu*s receive appropriate nourishment. *Rasayana* treatment thus aims at restoring the proper transportation of nourishment to all tissues of the body, which ultimately makes the body function as if it is a young one. Ayurvedic rejuvenation thus does not aim at turning a grey haired old man into a young Adonis, but at restoring the body's physiological mechanisms of metabolism to an optimum state in which disease does not develop and life does not end prematurely (ie. due to disease and not due to the natural lifespan every individual has).¹⁷

¹⁶ The order is *rasa* [the first product after digestion, some translate it as lymph], *rakta* [blood], *mamsa* [muscle tissue], *medas* [fat tissue], *asthi* [bone tissue], *majja* [bone marrow], and *shukra* [reproductive tissue].

¹⁷ This explanation of *rasayana* is based on my notes of how a teacher, a PhD in *rasashastra* from the same university I conducted research in, explained it to BAMS students. A similar explanation can be found in Babu 2008: 119-123.

According to Dr. Mahinda, *chandraprabhavati* produces *dhatu pushti* [nourishment of the body's tissues], and with the above explanation of *rasayana* in view, this is just logical: The *rasayana dravya shilajit* causes a problem-free circulation of *rasa* and all the other *dhatu*s of the body, with the result that all of them are nourished in an ideal way, which keeps diseases at bay. Exactly this is also the reason why *chandraprabhavati* has a multitude of effects ranging from improving the digestive fire, over correcting malnourishment, treating urinary tract infections and white vaginal discharge: an improvement in the circulation and nourishment of body tissues effects not just one organ or one location, but it influences the whole organism. "That is the difference between the ayurvedic treatment and the modern", says Dr. Mahinda: While a modern antibiotic *circulates all over*, only affects particular germs by killing them and then a maintenance of the so created pathogen free environment in the body is needed, the ayurvedic antibiotic *improves all-over circulation*, resulting in a "homogeneous environment", in which the body can get rid of what disturbs its equilibrium and thereby keep itself healthy. Whereas a modern broad spectrum antibiotic targets *multiple types of bacteria*, the ayurvedic one has *multiple sites of action*, which includes but is not limited to bacteria.

From the above descriptions and quotations emerges a tablet correcting both the main ayurvedic and biomedical root causes of diseases - a hampered digestive fire, an accumulation of undigested material (*ama*), a blockage in the transportation of nutrition, and microbial infections. The effect of this tablet and its mode of action as explained by the *vaidyas* of hospital J can be traced to the classical ayurvedic scriptures in Sanskrit as well as modern ayurvedic research conducted at post graduate teaching institutions all over India, in which modern scientific research standards, methodology and technology is used to evaluate the efficacy of ayurvedic formulations in the ontology and language of cosmopolitan medicine.

While this tablet, when argued for and used in today's ayurvedic practice, in its meaning of an "ayurvedic antibiotic" inherently fuses with the ayurvedic ontology it was born out of the acknowledgement of the germ theory of disease, it unanimously also supersedes the latter by achieving the efficacy of modern medicine - killing pathogens in their host - while avoiding its side-effects, and additionally causing a rejuvenation and an increase in physical strength and

overall health. It can treat *shvetapradara*, be it of infectious or non-infectious nature, by not only addressing its symptoms and root causes, but also by affecting the very nature of the soil it developed on (the body itself), which can either enable diseases to develop or resist them in the first place.

8 The Treatment: Garbhashaya-Griva-Mukha-Gata-Vrana

In the hustle and bustle of this Wednesday's OPD morning hours it is the turn of Shraddhaben, 32 years old, married since 15 years with two daughters. Both of her hands and legs pain, she says, when Dr. Paresh, a second year MD scholar, asks her, why she has come to the *Stri Roga* and *Prasuti Tantra* department today. Shraddhaben says she feels weak, has lumbar pain and *safed pani*, and since her last daughter was born ten years ago, she has - despite all good efforts (Dr. Paresh notes down "contraceptive history: NIL, coital history: 2/week") - not gotten pregnant again. She is sent to the examination room next door and as soon as the nurse shouts "Patient on table!" into the consultation room, Dr. Shreedevi, Dr. Paresh and I make our way over to Shraddhaben. The per speculum examination reveals "no signs of infection or inflammation, but white discharge and cervical changes", so Dr. Shreedevi. She turns to me and explains, "*shvetapradara* due to *garbhashaya-griva-mukha-gata-vrana!*", and as my expression seems to disclose that I can not follow her explanation, she adds, "That is, due to cervical erosion!". She orders Dr. Paresh to "note down on the case sheet: full erosion of cervix, stony hard, hypertrophied surface. Advise admission to hospital for *agnikarma* [cauterization]".

Two days later I see Shraddhaben again in the marble tiled operation theater of the hospital's in-patient-department. Every morning between nine and twelve a shift of *vaidyas* works in the operation theater and its adjoining rooms, performing various *karmas* (procedures) indicated in gynecological diseases, for example *uttarabasti* (administration of medicated oils into the uterus) in cases of infertility, *yoniprakshalana* (vaginal douches) with herbal decoctions for the symptomatic relief in infections, and cauterization procedures in cases of cervical polyps or erosions. Today Dr. Pooja and two other scholars are on IPD duty and I have decided to join them in this quiet part of the hospital to observe the treatment of Shraddhaben. But before I enter I have to keep my shoes on the stack with those of other patients and *vaidyas* outside the corridor leading to the operation theater, find a pair of O.T. *chappal* (flip flops for the use inside the operation theater) of my size from another stack, wear a blue surgical gown, cap, and mask from the autoclave container in the ante-room, and then soap and scrub my hands and arms down to my elbows.

Inside the operation theater three MD scholars wearing the same attire like me with latex gloves on their hands and a nurse in a white apron are preparing the cervical cauterization by disinfecting the patient's external genital area with the help of a surgical forceps and in Dettol dipped cotton swabs. On the first sight the operation theater of the *Stri Roga* and *Prasuti Tantra* department could as well be part of a modern hospital: The brightly lit, spacious room is equipped with air conditioners, surgical lights, autoclave machines, and sterilized instruments. The medicinal supplies cupboard holds syringes, anesthetics, antiseptic solutions and antibiotics. Only a closer look reveals that this is an ayurvedic hospital after all: there is an oil bottle here, a medicated herbal wick or a piece of an aloe vera leaf there.

My guide Dr. Pooja explains that in cervical erosion the cells containing mucus secreting glands normally present inside the endocervical canal have migrated to the outside of the cervical os and then undergone metaplasia (a change in the nature of cells), and so the patient is suffering from excessive, but non-infective white vaginal discharge. While this is a normal process often triggered by “low immunity, intercourse, sensitivity to condoms, pregnancy, previous infections and surgical procedures” as Dr. Pooja informs me, it is better to cauterize the cells since the woman's daily life is disturbed by the excessive discharge, and could also be a form of early cervical cancer. While in modern medicine a cervical cauterization is often done by an electric current sent through a probe, which creates the heat required for burning the tissue, the *vaidyas* in hospital J use a red hot iron rod. The one Dr. Pooja and her colleagues are using today is a special one, a “*svarna shallaka*, just like mentioned in the classics, a senior made it for her thesis research and borrowed it”.

The doctors explain that according to the ayurvedic scriptures the best results of cauterization are achieved by using a *svarna shallaka*, a probe made of gold, something a government Ayurveda hospital in India would not have the pecuniary resources for. Dr. Pooja's senior, an ayurvedic gynecologist, had invested her private money into getting an iron probe with a one centimeter tip of gold for her research project, and now the scholars of the department are lucky to have it borrowed for some time. When the golden rod is not available or a special indication or research thesis demands it, so Dr. Pooja tells me, cervical cauterizations in this hospital are also done with *vartis* (wicks made of medicinal

powders) or by *kshara* (herbal alkalies) - all of which are conducted in the same setting, but with slight variations in the instruments or substances used, as I would witness during my fieldwork later on.

Everything is prepared for the cauterization to start, Shradhaben is in lithotomy position and has finished her last phone call explaining to the person on the other end that she can't talk any longer, because her surgery is about to start. Her cervix is exposed with the help of two *vaidyas* holding a speculum each, and Dr. Pooja places the golden tip of the *svarna shallaka* in the flame of a little kerosene cartridge. As soon as its hot enough, she introduces the *shallaka* into the vaginal canal - careful not to touch its walls - and then lets the rod burn the red eroded area around the cervical os by touching it with the golden tip for one second at a time until the tissue turns white. Anesthesia is not needed, I am informed, as the cervix is not sensitive – and indeed does Shradhaben endure the procedure without the bat of an eyelid. As soon as Dr. Pooja is satisfied with the result of the procedure after reheating the rod several times and burning the affected area, the specula are pulled out, Dr. Pooja dips a tampon rolled out of a gauze piece into the little stainless steel tin containing *jatyadi tailam* [a medicated oil supporting healing] and places it in the patient's vagina.

Dr. Pooja tells me that Shradhaben will be able to go home within two hours, then is expected to have an increased watery discharge for a few days (which occurs due to healing), and should have no more lumbar pain or excessive white discharge from then on. If she will be able to conceive again remains to be seen.

The most apparent and simplified analysis of this site's and situation's interweaving of two systems of medicine in modern institutionalized Ayurveda would be to either recognize the dominance of cosmopolitan medicine's framework over vanishingly little ayurvedic aspects, or to juxtapose tradition and modernity at the example of a golden rod referenced to in Sanskrit scriptures used in the sterile conditions of a modern operation theater. A closer look at *shvetapradara* due to *garbhashaya-griva-mukha-gata-vrana* (cervical erosion, lit. wound at the opening of the uterus' neck) though leads away from such a simplification and into the complex fabric of modern Ayurveda, in which disease entities and their treatment modalities come into existence through the scholarly discourse and research work reflected in the postgraduate theses of ayurvedic scholars. These pieces of writing are part of the practice shaping modern

institutionalized Ayurveda, part of 'doing a disease' (Mol 2002), but have been ignored in accounts of how biomedical diagnoses are correlated with ayurvedic ones.

Naraindas for example attributes the correlations between ayurvedic and biomedical disease entities commonly referred to by modern ayurvedic physicians to the translations of the Sanskrit texts to English, due to which “the classical texts (...), by the sheer act of translation, have been forced to reckon with allopathic categories in the act of translation” (2006: 2667). “Each of these translations”, Naraindas writes, “attempt to make sense of ayurvedic concepts in terms of the then current biomedical concepts” (2006: 2666-2667), and since they were motivated by the pedagogy of modern educational institutions of traditional medicine, they carry over from books into classrooms and practice, and result in the modern *vaidyas*' “bilingualism that privileges biomedicine ” (2006: 2659).

Even though I agree without any doubt that the main direction of translation in the field of modern Ayurveda is (and has been since translation efforts began) from Sanskrit to English, and that it is difficult to almost impossible to translate ayurvedic terminology into a language like English, whose underlying ontology is so fundamentally different, I would like to draw attention to the way young ayurvedic doctors' and scholars' today engage with their objects of study and the involved translations.

The term *shvetapradara* appears first in the *Haritasamhita* (Choudhary 2013: 38), which is dated between 700 and 1000 CE (Meulenbeld 1999-2002, 2A: 60) and then again in the *Ayurvedadipika*, an 11th century commentary on the *Charaka Samhita* (Wujastyk 2012: 21). The term *garbhashaya-griva-mukha-gata-vrana* in contrast does not appear in the source texts of Ayurveda or their later commentaries (Kazi 2005: 24), and I was not able to locate any reference to it in modern ayurvedic textbooks, either. Where it does appear is in the research work of ayurvedic MD and PhD scholars, and as one working on the effects of *agnikarma* (cauterization) in *garbhashaya-griva-mukha-gata-vrana*, Jasmine Kazi lists as its first appearance in institutional research work a thesis from 1977 (2005: 6).

She describes the fact that an instrument resembling a speculum for the examination of *yonivrana* [lit. wound of the female reproductive tract, a term which

would include cervical erosion as well, as the term yoni [encompasses the whole genital tract] appears in the classical treatise *Ashtanga Samgraha*¹⁸, but a corresponding symptom or disease is not described anywhere. Kazi enumerates as possible reasons for this lacuna that this disease entity may be included under the general heading of *vrana* [wounds, any discontinuities in epithelial tissue], that it was not prevalent at the time the book was authored, or it was a “missed subject” (2005: 13). Missed it could have been for two reasons, writes Kazi: either the text's commentator responsible to elicit hidden meanings in the concise writing failed to elaborate on it because the “style of description was mainly symptom based” (ibid) – in which case this entity would belong under the category of *shvetapradara* – or because an examination of the female reproductive tract, despite the suitable instrument mentioned, was not common due to societal customs.

Today, the routine examination of the internal genitalia of women with a speculum enables *vaidyas* to visualize the cervix and diagnose what they see ayurvedically. So instead of having to rely for a diagnosis and subsequent choice of treatment on the symptomatology the woman discloses to them, they diagnose the changes in the normal color and continuity of the tissue surrounding the cervical opening based on ayurvedic diagnostic categories mentioned in the classical scriptures.

Kazi (2005) for example bases her argument for identifying what would be termed cervical erosion in modern medicine as a type of *vrana* on the Sushruta Samhita's description of various types of *vranas* and comes to the conclusion that “according to [the] classical concept of *vrana*, [the] disease entity described related with cervix ('cervical erosion') maximally matches with *vrana* of Garbhashaya Griva [neck of uterus=cervix]” (2005: 25, additions by L.G.) and that further “it is a clear fact that *vrana* of Griva, specifically erosion (...) [is] Kapha Pittaja *vrana*” (2005: 31, addition by L.G.). One of the suitable treatments of such *vranas* according to the Sushruta Samhita is *agnikarma* (cauterization), with either a medicated wick as Kazi used in her clinical study, or the golden rod described in the scene of my fieldwork in the beginning of this chapter.

Kazi here uses the “classical concept of *vrana*” as the base for comparison, and reaches to the conclusion that cervical erosion, as it is described in the textbooks of modern medicine, is its rightful equivalent and even takes the ayurvedic

¹⁸ The author and date of this treatise is controversial (Meulenbeld 1999-2002, 2A).

diagnosis one step further by differentiating the *doshic* subtype (*kapha-pittaja*) of *vrana* it belongs to. The way the research scholar argues then is not an attempt to explain ayurvedic concepts through the ones of modern medicine (Leslie 1992) or an insufficient translation of terminology (Naraindas 2006), but shows the practical application of ayurvedic knowledge to a phenomenon made visible by cosmopolitan medicine's speculum. This diagnosis is then compared to its closest equivalent in biomedicine – eventually the prerequisite for the scholar's comparative study of the effectiveness of modern electrocautery versus ayurvedic *agnikarma* in one and the same condition, be it called *garbhashaya-griva-mukha-gata-vrana* or cervical erosion – which is without question most safely and efficiently conducted in the sterile conditions of a well-equipped operation theater.

All of the research work of modern ayurvedic scholars could of course be interpreted as the rhetoric of an Ayurveda which needed to not only parallel, but surpass European medicine in an Indian postcolonial quest for a national-cultural identity (Langford 2002), one which only defines itself in and through a constant struggle with hegemonic biomedicine (Sujatha 2011), or one which had the language of an incommensurable system forced upon itself through pedagogic efforts (Naraindas 2006).

While aspects of these arguments may be true and certainly deserve consideration in studies about contemporary Ayurveda, modern *vaidyas* who have passed the strict entrance exams for postgraduate studies are in my experience much more passionate about their subject than BAMS students, to whom a seat in an Ayurveda college is often just the second best choice to one in modern medicine (Naraindas 2006: 2662). These young scholars with the way they correlate ayurvedic and biomedical disease entities creating the unique interweaving of allopathic and ayurvedic medicine characteristic of modern professionalized Ayurveda do not just act out of a need for justification or defense, or from a position of inferiority, but have to be considered and studied in their own right - as scholars and scientists of a particular system of medicine who argue and work within that system's framework to arrive at statements of truth and validity.

And even *if* someone were to interpret the ayurvedic scholars' argument described above as a, maybe subconscious, a posteriori construction justifying the

correlation of a biomedical term with one of Ayurveda retroactively¹⁹, it would still be the antithesis of what is usually portrayed as the typical direction of translational flows between Ayurveda and Biomedicine; it would still be the story of a biomedical term translated into Ayurveda's own language, Sanskrit, and therefore incorporated into its medical and linguistic repertoire. It would, just like Dr. Kazi's line of argument in her thesis, still speak of today's ayurvedic doctors' and scholars' agency, which clearly emerges from the way they engage with their subject: a self confident intertwining of ayurvedic and biomedical elements, aware of what the amalgamation of both can contribute to their patients' health and well-being.

9 Conclusion

My investigation into white vaginal discharge in a government Ayurveda university hospital in North-West India revealed that what the *vaidyas* correlate with leukorrhea - *shvetapradara* - is a whole constituted of a multiplicity of objects that go under the same name, that indeed have “a complex present, in which their [the objects'] identities are fragile and may differ between sites” (Mol 2000: 15).

In the fleshy affair of day to day life in hospital J I have attempted to locate *shvetapradara* wherever it is enacted by following the ayurvedic doctors in their practice regarding vaginal discharge, not halting my observations when the talk stopped and fluids of the body, instruments, and surgical procedures gained center stage – just as Mol asks of ethnographers of diseases (2000: 27).

A praxiographic approach, according to Mol, requires to “attend to physicalities” (ibid), to speak freely about bodies and diseases, and to address the materialities of medical practice: The *shvetapradara* I observed in modern ayurvedic practice is a flow of female bodies fluids, something sticky, white, copious, curd like, yellowish, excessive, itching, normal or abnormal. Something staining underwear, something embarrassing and personal. Something visualized through a speculum, something sticking on instruments and gloves, something infectious or non-

¹⁹ The most approximate Sanskrit translation of the term 'cervical erosion' is *garbhashaya-griva-mukha-gata-vrana*, with the word for the anatomical structure of the cervix (which remains unnamed in the Ayurvedic scriptures) constituted of a composite from *garbhashaya* (uterus), *griva* (neck) and *mukha* (opening, mouth), erosion finds its closest equivalent in the word *vrana* (=wound), and *gata* (=gone) denotes what this wound has affected (the cervical opening).

infectious. It is tissue that migrated away from where it is supposed to be, turned bright red and hardened, tissue which needs to be burnt away with a golden rod, a herbal wick, or alkalies. Something treated with ayurvedic antibiotics, vaginal douches, oil application and herbal powders. It is a diagnosis and a symptom, an umbrella term for many other diseases appearing in ayurvedic scriptures, something noted in the register of the clinic. It is a Sanskrit word leaving room for interpretation. It is leukorrhea, which in itself is sometimes white and non-infectious, sometimes of any color and infectious. Under the microscope of the research scholar *shvetapradara* is bacteria, in her thesis it is these bacteria all women who complain of *safed pani* have. It is something pathological and something physiological, something indicating improper circulation of fluids, hormonal imbalances, sexual excitement, disturbances in *kapha* and *vata doshas*, microorganisms, and *dhatu* loss - albeit a harmless one.

I assumed that with all of these obvious frictions between the various *shvetapradaras*, their coordination into a singularity required by a monistic episteme must be prompted by the threat of incommensurability, just as Mol (2002) describes for the multiplicity of atheroscleroses in a hospital of cosmopolitan medicine. If one were to follow the authors I have quoted earlier on and especially under the light of the history of modern Ayurveda with all the political and educational struggles surrounding the integration of Ayurveda and biomedicine, the threat of incommensurability must be ever present in modern Ayurvedic education and practice. In fact, according to them, it is the attempted - but unsuccessful, since impossible - reconciliation of these two incommensurable systems of medicine in modern institutionalized Ayurveda, which is responsible for modern ayurvedic teaching hospitals' "disturbances in form and function" (Langford 2002), the *vaidyas*' "make-shift structure" (Leslie 1992: 195) between traditional concepts and biomedicine, and modern Ayurveda's mimicry of cosmopolitan medicine (Langford 2002, Naraindas 2006), which in the end make it an inferior version of what it tries to copy.

Accordingly, as a German ayurvedic student grown up with an intellectual tradition which is keen to distinguish between what is commensurable and what not, I was upset that I had to learn biomedicine when I had come all the way to India to study Ayurveda, was annoyed when I had to learn the names and action of antibiotics when I had chosen Ayurveda to get away from just that, and sometimes felt pity

for my teachers whom I thought had so little trust in their own science that they needed to justify its existence in the terms of Western sciences.

But as my stay as an anthropologist at hospital J revealed, the question of incommensurability or of managing two epistemologies never arose for the *vaidyas* I have worked with during my fieldwork, neither in what they said nor what they did. Since I was interested in the coordination of the differences between Ayurveda and cosmopolitan medicine and wanted to focus on the way the *vaidyas* switch between different systems of medicine, I looked for points of tension and friction between these two incommensurable entities – and was surprised and sometimes even unsettled by the observation that no one seemed to perceive them as such apart from me.

It was when I allowed myself to explore modern ayurvedic practice *as it is* without reducing it to its individual theoretical constituents that I could reconsider what it was that was practiced and taught at Indian Ayurveda educational institutions. Ultimately this letting go enabled me to catch a glimpse of Indian ayurvedic practitioners' ontology in practice, and to understand the need of a relativist approach true to its name to leave behind one's own expectations of systematicity and notions of what exists, when, where and how it exists – in short, to be open to discover commensurability where it is least expected. The classification of Ayurveda and biomedicine into two incommensurable entities (both in theory and practice), is as much true as it is not, since “no entity can innocently stay the same throughout the story, unaltered between various sites. There are no invariable variables.” (Mol 2002: 121).

I propose that modern institutionalized and professionalized Ayurveda be anthropologically studied as its own system of medicine, which surely is constituted of ayurvedic and biomedical aspects, but the whole of which is different than the sum of its parts. Without leaving out of sight a historically informed approach, contemporary Ayurveda as practiced by its scholars and professors researching, treating, teaching, and studying at universities and their hospitals in India today needs to be studied in its own right. To research and write about diseases of or referring to ayurvedic medicine, its thought and practice, *vaidyas* need to become to the anthropologist what the doctors of a Dutch hospital were to Mol:

“Doctors become the social scientist's colleagues (...). They stop being “mere” objects of research whose interpretations may be listed and related to their historical and cultural context. But neither are they (...) professionals who have knowledge of “disease”, to which the social scientist may add knowledge about “illness”. Instead, territorial boundaries of professionalism are starting to leak.”
(Mol 2002: 27)

To implement what Mol advocates in a setting like a modern ayurvedic hospital and its practice, which since long has anthropologically been viewed from one particular perspective, requires courage, as Leslie²⁰ needs to be inverted: There is no doubt, that modern Ayurveda can be unsettling when anthropologists realize that it is grounded in a different conception of knowledge than the one that in their science forms their sense of reality and truth. And no wonder they separate humoral concepts from biomedical knowledge. A way of thinking is at stake in their interpretation of Ayurveda, and not just an analysis of a medical system.

²⁰ Referring to Leslie as quoted on page 18

10 Appendix

10.1 Case-taking

Asso. Prof. & Head
SRPT Dept

No. AYURVED HOSPITAL (O.P.D.)

अनुस्नातक आयुर्वेद अस्पताल (बहिरंग विभाग) स्नातकोत्तर आयुर्वेद अस्पताल (बहिरंग विभाग)

ओ. पी. डी. रजिस्ट्रेशन 5 APR 2013

1667 तिथि लिंग: पृ./स्त्री/श्री. वय: वर्ष 28 माह

नाम ओ. पी. डी. निदान श्वेतप्रदर

निवास Prayagra

तिथि	लक्षण	चिकित्सा पथ्यापथ्य सहित	औषधि दिवस	चिकित्सक के हस्ताक्षर
4/13	Co - white discharge.	Rx		
	Baenachi	1) दशमूलदीपिका - 10 gm		
	Leg Cramp.	2) अशोक - 1 gm		
	Itching kelus.	मिथु - 1 gm		
	Burning micturatio	युग्म - 1 gm		
		शुद्ध - 1 gm		
		उत्तम - 1 gm		
	Kep - 10th day			1x 1gmie
	Mh - 4-5	Ref of Mod. Rx/day		रम्य.
	26-28			5m
	OH = C ₁₂ P ₂ A ₀ L ₂	3) ललादि - 5m		for 2000m
	L.D - 542			
	Colhr - L. done.	4) शुक्यमादी - 2 tab		
	Colhr - 24ml			1x 2 tabs
	flu			
	Apr 14	5) पंचमूलदीपिका - 10 gm		for 2000m
	Su 14	शुद्ध - 10 gm		
	Exp - burning			for 2000m
	Shool - Ref			2000m

Shwet

fig 1: A case sheet of a shvetapradara patient

In the following the system of noting down the information on the patients' case sheets are explained.

c/o [complaint of] = The complaint of the patient in his or her words, noted down in English.

M/L [married life] = If the woman is married, the duration of married life - actually referring to sexual activity, since these two are generally expected to coincide in India - is recorded; if the woman is unmarried, it is usually written in big letters at the top of the consultation form, circled so as not to be overlooked. This fact is not only important with regards to the diagnosis, as the fact of being unmarried excludes the possibility of a sexually transmitted disease, but also in case an examination is necessary: Unmarried women (ie. virgins) are not expected to assume the lithotomy position for an examination (which in these cases was not done with a speculum, and consisted of inspection only), as they were obviously uncomfortable, extremely bashful and scared of this position alone.²¹

M/H [menstrual history] = The menstrual history occupies a quite substantial position in the case-taking: The duration of bleeding in days per cycle is written atop a horizontal line, underneath the interval at which the menstruation occurs. Three lines are then drawn fanning out from this horizontal line, at the end of which is indicated a) if the menstruation is "regular" or "irregular", b) is "painful" or "painless", and c) "[sanitary] pads per day", which is used to determine if the bleeding is extraordinarily heavy or in the normal range. The *vaidyas* consider a change of pads three times per day as "normal", while anything less would be indicative of hypomenorrhea, and four or more point towards menorrhagia. The assumed potential of such a question objectively determining the heaviness of bleeding surprised me, as I thought the frequency of changing pads to be not only a matter of the amount of menstrual blood, but one of thickness and quality of pad, personal comfort and understanding of hygiene. But when I asked one of the professors and later again a student about this dilemma, I met with an uneasiness (or unwillingness?) to talk about the details of women's pad-changing habits and did not get any further explanations.

²¹ Dr. A. from the example above forgot to ask the patient about the duration of her married life. Normally the Professors would reprimand their students if they noticed their students had left out any of the basic questions required for a comprehensive gynecological case history – in this case the Professor oversaw Dr. A's mistake.

O/H [obstetric history] = The obstetric history is noted as GxPxAxLxDx, wherein x is a placeholder for the number of gravidity (G = the number of times a woman has been pregnant), parity (P = the number of births a woman has given), spontaneous or induced abortions (A), living (L) children, and dead (D) children; added are how many years ago the last delivery took place, if the baby was born at home or in a hospital, and, if applicable, the last abortion.

C/H [contraceptive history] = The *vaidyas* then note down the contraceptive history, but rarely ask their patients about the category of coital history, even though the professors repeatedly mentioned this to be an important indicator if there are any problems in conception. When I, having assumed the to me ascribed role of the fellow *vaidya*, pointed out to one of the PhD scholars, that he hadn't asked his patient about her coital history yet, he looked uneasy, and then without asking the woman noted down "1-2/week", which is what the doctors of this department note down as "normal". Another way of indicating a healthy coital history is to simply write "regular" under this heading, leaving it to the eye of the reader what this entails. If the woman was visibly beyond menopausal age this question was in the majority of cases not addressed.

P/H [personal history] = The last subject of a consultation with an ayurvedic gynecologist in hospital J is the patient's "personal history", which consists of "appetite, sleep, stool, and urine". The patient's explanations are noted down on the case sheet with a particular set of words, consisting of "normal" or "regular", "increased" or "decreased" (often indicated by ↑ and ↓), and "disturbed". Possible details under urine are "increased frequency", or "burning"; stool is described as "constipated" or "diarrhea", if not regular.

10.2 Pictures

11 Bibliography

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