Title: Patient Agency Revisited: “Healing the Hidden” in South India
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It is often argued that biomedicine alienates patients from doctors, from ailments and from understanding treatment processes, while indigenous and alternative healing systems are portrayed as respectful of patients and their experience. Specifically, South Indian siddha medicine has been seen as diverging from biomedicine in empowering its patients. This approach not only assumes biomedicine to be a homogeneous practice, but also lumps together diverse therapeutic techniques under the labels of “traditional” or “alternative.” Analysis of a manual subdiscipline of siddha medicine cautions against such analytic imprecision and active/passive binaries in physician–patient encounters. Practitioners of vital spot medicine claim to “heal the hidden.” They rarely communicate diagnostic insights verbally and object to auxiliary devices. However, their physical engagement with patients’ ailing bodies highlights the corporeal nature of manual medicine in particular and processual, situational, and reciprocal characteristics of curing in general. [embodiment, manual medicine, secrecy, siddha medicine, South India]
Annemarie Mol (2008), writing on the logics of choice and care in Europe, has similarly criticized generalizing notions of active/passive patients. She has noted that treatment is a dialectic process influenced by the logics of choice and of care. Rather than assuming either active or passive patients, it would be more inclusive to analyze the “logic of care” involved (Mol et al. 2010:9). In other words, to adequately understand healing processes, we need to recognize interactions between patients and healers as more complex than simple dualisms suggest. Taking into account the various agencies that influence treatment choices and healing processes also dissolves the problem of patients as active (subject) or passive (object). For Mol, care is not a transaction, but an interaction; care is not a product but “a process: it does not have clear boundaries. It is open-ended” (2008:18). In this article, I analyze the particular logic of care involved in a form of indigenous manual medicine in Tamil Nadu, South India, to emphasize its processual and physically reciprocal character.

Varma maruttuvam, “vital spot medicine,” is practiced in the Kanyakumari district of Tamil Nadu, the southernmost part of mainland India. It is generally recognized as a part of siddha medicine, one of the codified indigenous medical systems of India. Sujatha has recently described patients of siddha medicine as “knowing” (2009), since they are knowledgeable of and are actively involved in treatment processes; as such, siddha can be contrasted with biomedicine and its patients.

Practitioners of vital spot medicine are called ācāy. They have largely enjoyed a hereditary, noninstitutionalized type of education, which enables them to offer treatments addressing ailments of varmam (i.e., “vital spots,” or vulnerable locations of the body). Related therapies include manual stimulations of particular points to retrieve patients from unconscious states, long-term treatments for chronic ailments, setting of fractures, and massages. Practitioners of vital spot medicine conduct diagnosis and treatment secretly to avoid observation by witnesses; they also generally refrain from communicating diagnostic insights to patients. Rather, ācāyś claim to “heal the hidden” and regard vital spots, their locations, and their manipulation as something that should not and cannot be disclosed. This approach to curing calls into question the idea of knowing, emancipated, or active patients in siddha medicine.

Through tactile attention to their patients’ bodies in diagnosis and therapy, ācāyś address ailments without any auxiliary devices such as radiographic images, but also without giving verbal explanations to patients. Ācāyś state that their manual, body-based therapies cater to the specificities of vital spots, which are physical entities that can be healed by their embodied skills but not communicated. They are unwilling to do so, not only because of the esoteric nature of their practice, but because they also find it difficult to translate their manual techniques and tacit knowledge into language. The practitioner’s hands and feet on the one side, and the body of the patient on the other, are brought into intimate contact, in the process of which diagnosis and treatment are conducted. As will become apparent as the ethnographic narrative unfolds, curing in vital spot therapy rests on this embodied communication between patient and physician. In the case of varma maruttuvam, describing this process of situational and physical reciprocity advances our understanding of curing more than the active/passive binary.

Vital Spots and Varma Maruttuvam

Varmam vital spots are vulnerable locations of the body, which, when affected, may cause ailments ranging from light, even unnoticeable symptoms, to severe pain, or effects as serious as death. Vital spots can be utilized for purposes of combat as well as therapy, and ācāyś are frequently exponents of martial arts practices called varma ati or “hitting the vital spots,” as
well as of varma maruttuvam, “vital spot medicine.” Its therapies are generally recognized as part of siddha medicine (Irācjēntirā 1996), an indigenous form of health care found mostly in the southeastern Indian state of Tamil Nadu (Hausman 1996; Weiss 2009), while the corresponding martial arts resemble the better-known kalarippayātu martial art form of Kerala (Zarrilli 1998). Since vital spots may be used to incapacitate opponents, ācārīs generally maintain strict confidentiality regarding their locations and ways of stimulation. For them, to reveal such potentially harmful information would be unethical.

Practitioners explain the vulnerability of vital spots as related to the concentration in them of pirāṇam, a kind of circulating vital force. Any trauma to a varnam, for example through physical impacts, inhibits the circulation of this vital force. This, in turn, deranges the three psychophysical functions or tōcam: vītam (gaseous/pneumatic), pīttam (acidic), and kāpam (unctuous), and the five physical structures or rātu: rasa (chyle), rākta (blood), māmsa (muscle), medas (fat-tissue), asthi (bone), mājja (bone marrow), and śukra (semen fluid) (see Irācjēntirā 2006). Vital spot injuries therefore potentially cause detrimental effects to all aspects of psychophysical health.

**Diagnosing Varmam: “Seeing” the Pulse**

Pulse examination, nāti pār-ttal, literally translates as “seeing the pulse” and constitutes the main diagnostic method in both vital spot and siddha medicine. Practitioners often emphasize their extraordinary pulse examination skills, which, they say, surpass even modern imaging devices (Narayanaswami 1975:30). Ācārīs hold that vital spots are nonmaterial and hence neither visible nor detectable via dissection. For this reason, they question the value of imaging devices for their practice and may even refuse to look at X-ray scans that patients bring along after having been diagnosed elsewhere. As one ācārī stated, “Varmam can’t be seen on these images.” It is important to note that seeing the pulse is, in fact, a tactile diagnostic method that does not depend on vision at all, but consists of sensing the pulsations of patients’ radial arteries at the lateral aspect of the forearm below the wrist joint. Here, the tōcam processes are assessed regarding imbalances, as is the pirāṇam vital force regarding its circulation, by three fingers of an ācārī’s hand.

For siddha medicine in general, pulse examination has been described as a state of equipoise between patient and physician (Daniel 1984; Sujatha 2009). Not only are vitiated processes and blocked vital force detected by this method, but physicians have also become aware of their own pulse while measuring that of their patients. Ācārīs attempt to modulate their own pulse so that it coincides with that of their patients. This allows for a state of empathy, during which they detect imbalances of tōcam and the flow of pirāṇam in a patient’s body. I was told that in this way ācārīs conduct a thorough (tactile) scan of a patient’s body, tracing even the most trivial abnormalities. Moreover, pulse diagnosis is a complex process requiring tactile skill, concentration, and experience because seasons and time of day, as well as the age and physico-mental state of a patient, must be taken into account. Narayanaswami writes that, “long practice is necessary, for this is more a subjective evaluation of the condition of the body than an objective one” (1975:33).

Sujatha regards pulse examination as an icon of an allegedly fundamental difference between siddha medicine and biomedicine with regard to their respective processes of knowing an ailment. According to her, biomedicine, being laboratory centered and following strict disease categories, is comprehensible only to doctors, as “diagnosis, decisions about treatment and its evaluation take place in the language of experts” (Sujatha 2009:77), while the illness experiences of patients are not included.

According to Sujatha (2009), siddha does not create a similar hiatus between patient and practitioner, nor between experience, knowledge, and diagnosis, and hence not between...
illness and disease, since it draws on the experiences of both physicians and patients. Since the 1970s, studies in medical anthropology have distinguished “illness” from “disease.” The former describes the illness experiences of patients/laymen, the latter denotes the disease according to doctors’/specialists’ understandings and concepts (Good 1996; Kleinman 1980). Disease is thus seen as an objective, scientific fact in biomedicine, whereas illness is seen as an expression of subjective experience and thus is unreliable. That is why biomedicine has been accused of splitting off subjectivity from objectivity and patients from physicians (Taussig 1980:8).

However, Mol convincingly argues that it is high time for social scientists to go beyond the illness/disease dichotomy (2002:27). She stresses that diagnosis, in particular, is performatively produced between doctor and patient: In the consultation room, both physician and patient act together to jointly give shape to the reality of the patients’ ailment. This diagnostic acting together of physician and patient can be well illustrated using the example of pulse examination in siddha medicine. In fact, this has been done so before: Nāṭi pulse examination, it has been argued, allows for a momentary merger of physician and patient, a state of “consubjectivity” (Daniel 1984; see Sujatha 2009), since tactile experience is a mutual process, consisting of touching and being touched at the same time (see Van Dongen and Elema 2001). In this sense, Sujatha argues that in siddha medicine, “the patient is not merely an object of the physician’s investigation through diagnostic equipment” (2009:79). The divide between physician and patient is neutralized and replaced with consubjectivity in nāṭi pulse reading as the siddha physician experiences the suffering and humoral imbalance of the patient. The latter, according to Sujatha, is ultimately a “knower” of diagnosis and treatment (through what she calls “sensory knowing”) (Sukatha 2009:79).

However, contrasting patients of so-called traditional medicine with biomedical patients, with the former imagined as active, emancipated, and knowledgeable, and the latter as passive, dependent, and kept in ignorance, does not advance our understanding of the dynamics of the process of curing. Moreover, although it is true that siddha physicians try to gain in-depth understandings of patients’ ailments by way of empathy and skilled pulse reading, it is necessary to critically examine the notion of these patients as being emancipated and informed.

**Healing the Hidden**

When I arrived at the small dispensary of Ramachandran, the practitioner was consulting with patients. Not wishing to interrupt, I took a seat outside on the veranda, from where I overheard that a teenage patient inside had had a fever for 32 days. The patient’s parents were present and lamented that all examinations previously conducted in a hospital had been inconclusive. Therefore, and because the boy had recently been involved in a fight, they considered the ailment to be “varmam[-related]” and had approached Ramachandran. The ācār, after having palpated the patient’s neck, pronounced that this was indeed varmam, and that the fever would abate after three successive massage sessions, at a total cost of 1,500 rupees. The parents, surprised by this amount, demanded to know what the therapy included. From here on, I cite my field notes:

Ramachandran: How dare you question me? Who is the ācār? You or me? Are you going to treat the boy yourself? (…) If you go to see a doctor in a hospital, will you ask him, “How will you treat,” or, “What does this injection contain?” Certainly not! Patient’s mother: It’s not like that! Don’t misunderstand me—my father was also an ācār.
R: Then let him cure the boy! If you know about these things, how dare you question me! Vital spots are a secret matter!
PM: Yes, we know. But can’t you tell us how you will treat our boy, and what it is he is suffering from?
R: It’s not possible. We are finished. Now go.

I was taken aback by the practitioner’s angry response to being questioned about his methods. It seemed to me that a medical consultation had been turned into a dispute because of an offended ego. After all, the ācāṅ had virtually kicked out a patient in need of medical care without even attempting treatment, something that appeared to me to be utterly insensitive.

Ramachandran later explained that the parent’s behavior had been wrong because it was improper to enquire about the modalities of vital spot treatment. A patient visiting him had to consent (ottakkaṇum), otherwise treatment was not possible. I must hasten to assert that uncompassionate behavior is an exception among ācāṅs, most of whom have great empathy for their patients. Ramachandran himself struggled to explain his reaction, saying that it was simply not possible to tell patients what the ailment was or how he would treat it. This had to do with the nature of varmam: Such spots, the ācāṅ declared, are potentially dangerous, therefore, since they might be misused, they must be kept secret. Disclosure of locations and stimulation methods of vital spots could damage the lives of persons and the reputations of practitioners. Moreover, there was no sense in explaining the insights of his examination, the nature of the ailment, or the treatment as none of these would be understood: In the words of Ramachandran, what ācāṅs treat is what is both “kept concealed” and “itself hidden” (maṟaitta veccatum maṟaintappatṭatum). In other words, vital spots are not only secret because they are not disclosed but also because they are noncommunicable aspects of the physical body.

**Invisible Spots and Tracing the Secret**

According to some scholars, the development of diagnostic imaging devices has ensured the primacy of the sense of vision in biomedicine (Foucault 1973; Kember 1991). Soon after the invention of radiography by Wilhelm Roentgen in 1896, images of body structures and organs became essential for traumatological diagnostics in Western countries. Besides, the utilization of imaging devices became important in distinguishing legitimate, trained physicians from allegedly unqualified practitioners or “quacks” (Hinojosa 2004b:268). But the use of such diagnostic tools in biomedicine “reveals attempts at making an ‘objective’ diagnosis through clinically isolating the medicalized site,” encouraging “the idea that injury can be isolated, captured, and studied at a remove from the sufferer” (2004b:282–283). It has been argued that such an approach renders patients’ experiences and symptoms—and even the patients themselves—of secondary importance, subordinated to the images produced (Taussig 1980:8), since health, disease, and efficient cure in biomedicine are determined by tests, “embodied in a techno-legal apparatus and situated entirely outside the felt awareness of the sufferer” (Naraindas 2006:2662).

Ācāṅs, on the other hand, dismiss radiography and imaging evidences, claiming that diagnosis of vital spots is a highly intricate process, only graspable by experienced practitioners. Admittedly, X-ray records can serve a useful purpose with their before-and-after images of once-broken bones, subsequently mended after therapy, and practitioners may sometimes keep scans that testify to their healing prowess (see Hinojosa 2002:26). Nevertheless, ācāṅs generally say that vital spots are hidden and can neither be detected by
scans nor by the eye, since neither pirāṇam nor vital spots are visible. Both categories can only be sensed by practitioners through their own bodies.

Another diagnostic modality utilized by ācāṅs is palpation (toṭu-ṭtal, literally “touching”). A practitioner’s hands skillfully palpate body surfaces, carefully sensing variations in the structure of tissues and vital spots. Physical trauma at a vital spot causes a local blockage of pirāṇam vital force, which can externally be sensed as a localized coldness (Nicivilcaṇ 2003:50; Chidambarathanu Pillai 1995:69). According to ācāṅs however, neither patients nor unskilled individuals can locate this because discerning such localized changes in body temperature is a difficult task that depends on detecting pirāṇam and vital spots in patient’s bodies and requires long years of practice.

To become aware of their own vital force and of that of their patients, ācāṅs practice exercises that develop abilities to sense pirāṇam concentrations. These include pirāṇāyāmam or “pirāṇam regulation,” sets of breathing exercises that are mostly known in relation to Yoga, and generally translated as “respiratory control” (Eliade 1970:53). Such exercises consist of deliberate modifications of the rhythm of breath by slowing down and equalizing patterns of inhalation, exhalation, and retention of breath. This has a calming effect but also allows for experiencing and influencing pirāṇam. For ācāṅs, this is required for detecting differentiations in temperature and localizing vital spots when palpating patients. Locating varmam spots through palpation therefore requires paying tactile and kinesthetic attention to patients’ bodies and to pirāṇam. The corporeal knowledge that underlies this technique is entirely the domain of specialists. Ācāṅs, moreover, seldom communicate their knowledge and rarely enlighten patients regarding diagnostic insights or their therapeutic procedures. By rejecting diagnostic images that their patients frequently bring along, they underpin their expert authority on vital spot ailments.

Curable–Incurable and Signs of Death

It might be argued that a more fitting translation for varmam is “lethal spots” rather than vital spots.² Potentially dangerous to life, practitioners have to evaluate every varmam affliction with regard to its being lethal or treatable (Irācāmaṇi 1996:25). In fact, there are signs by which ācāṅs estimate a condition to be curable, cāttiyam, or incurable, acāttiyam. The manuscript Varmapīrānki tiravukōl mentions symptoms such as “eyeballs falling to one side, emission of urine [and] feces” as “death signs” (cākūrti) (Nicivilcaṇ 2003:52). Some ācāṅs hold particular loci to be incurable by definition; hence any impact to these would be potentially fatal. According to Chidambarathanu Pillai (1994:46), 81 of the total of 108 spots are incurable and 27 are curable. Further, for each vital spots there is a stipulated amount of time during which treatment of an affliction is promising, whereas after its expiration an ailment becomes incurable. One of the shortest time spans is given for tilartakkālavarmam, a spot on the forehead. To save the life of the patient, treatment has to be concluded within 90 minutes of finding this affected spot (Chidambarathanu Pillai 1994:183).

If ācāṅs assess that a situation is incurable, they administer no treatment. Rather, according to some practitioners, “it is pre-eminent to send [the patient] away without administering medical treatment” (Irācāmaṇi 1996:25; see Chidambarathanu Pillai 1995:69). Textual sources support this view. The manuscript Varmapīrānki tiravukōl cautions, “Do not venture to treat” (Nicivilcaṇ 2003:52), and the Varmakkāṇṇati gloomily states, “If [an ailment is] acāttiyam, [the patient] is sure to die. Beat the paṭt [death drum], for his life will expire” (Mariyajočap N.d.:27). For ācāṅs, an incurable case is not only one where treatment is futile, but one in which a practitioner must not administer treatment. If treated nonetheless, one informant explained, “In case a patient dies, this will be seen as the ācāṅ’s fault.” A patient’s death may be ascribed to malpractice, not to the original injury, and the reputation of
a practitioner might be ruined. Alternatively, practitioners may even become victims to (physical) attacks by patients’ relatives (see Sujatha 2009:83).

Even signs that are not directly connected to the physical condition of a patient may provide clues about the nature of affliction. These are called *latcamam*, “symbol,” an aspect not confined to vital spot medicine but found in other prognostic and healing procedures in South Asia (Nichter 2008:188). Manuscripts mention that if, for instance, a messenger, bringing a report of an accident, is seen “holding a post or pillar with his right hand or (...) the bar of the roof and standing on a single foot” (Mariyajocap N.d.:39), an *acari* can ascertain, even from afar, that therapy is futile and should then not treat the patient. Incurability of ailments is likewise detectable if persons accompanying a patient carry tools, such as a spade (*maṇveṭṭi*). A buffalo (*erumai*) crossing the path of a patient who enters a dispensary signals imminent death.6

Although some practitioners dismiss the idea of rejecting patients on the basis of such signs, I did see one *acari* advising a patient suffering from a fractured ankle to “go to the hospital and see a doctor.” There, he said, the ailment would be taken care of appropriately. I was surprised to hear this, and I inquired after the patient had left if the *acari* honestly thought the patient was better off in a hospital. The practitioner demurred, stating that the injury could not be cured at all. He added, “No matter what treatment, there will be problems all his life. If I treat and it doesn’t heal, the family will scold me, thinking I’m a bad physician. Therefore we should not treat such patients. If I treat him, he will blame me, not his accident!”

Such signs, however, appear never to be communicated to patients, who are left unaware of them and their meanings. The practitioner cited explained that he would never disclose a diagnosis regarding curability or incurability to patients or their families. “How is it possible,” he asked, “to tell anyone that their ailment is not curable?” Such an act would neither meet with comprehension or acceptance, nor would it be in any way helpful. Thus, *acaries* do not normally inform patients of their diagnoses regarding the nature and (in)curability of a disease, and this holds true for most aspects of the vital spots.

However, although it may not be possible to speak of reflectively knowing, active, or empowered patients in the case of vital spot therapy, it is necessary to analyze the particular mode of curing involved. This analysis helps to emphasize the situational, corporeal, processual, and interactional character of this manual medicine.

**Healing the Vital Spots**

If affliction of a vital spot is assessed and estimated to be curable, most *acaries* use external, manual techniques for treatment. These fall into the categories *ofiikkumugai*, emergency measures, and *taṭavumugai*, specific massage methods. 

*Ilakkumurai* is a kind of emergency treatment, administered as fast as possible in vital spot injuries. It invariably includes stimulations of a particular category of therapeutic spots called *ataṅkal*. Etymologically, *aṭaṅkal* is derived from *aṭaṅku-tal*, which means “[t]o obey, (...) to be subdued; (...) [t]o cease” (Tamil Lexicon 1982:34). One *acari* referred to the therapeutic spots as “main switch,” which had, as it were, to be flicked after an injury. Thus activating a specific therapeutic spot, a varnam affliction is subdued through regulating the blockage of *pirāṇam* vital force in the body. Revived by this method, an unconscious patient regains consciousness. *Aṭaṅkals* can also be deployed for giving relief for various ailments, and particular spots may be stimulated according to specific conditions (Irāĵentirai 2006:364).

The general goal of such stimulation of therapeutic spots is to “relax,” in Tamil *ilakkutal*, and hence the overall emergency method is called *ilakkumugai*, or “relaxing; relaxation method.” However, “relaxation” here refers to vital loci and *pirāṇam* circulation—
but this is not necessarily perceivable by the patient, nor is it always pleasant. The relaxation method denotes the restoration of a state of bodily equilibrium that has been upset by a varmam affliction.

If a vital spot is traumatized, pirāṇam circulation gets blocked. To be precise, this has to be countered by relaxing the afflicted varmam, the blocked pirāṇam vital force and the whole body. By stimulating an aṭaṅkal, a corresponding vital spot is stimulated as well, which effects the slackening of the afflicted spot and the release of pirāṇam blockage. For each specific case of a spot being affected, one or several adequate aṭaṅkals thus have to be known and correctly stimulated for counteracting an affliction. Practitioners cannot simply press anywhere, since only the complete knowledge of varmam spots and their corresponding aṭaṅkal loci enables therapy. Moreover, there is no uniform manipulation method: Practitioners use specific techniques of pressing, turning, or pinching, executed by intricate finger positions or wooden sticks for different spots.

Aṭaṅkals are especially concealed and are only handed down within families or closed practitioner lineages, who are reluctant to communicate their locations and usage to outsiders. Many ācāryas claim to know “secret therapeutic spots” (irakacyamāṇa aṭaṅkal), considered to be most effective, yet unknown to other physicians (Jeyrāj 2007:60). Even close relatives of patients are sent out of the treatment room when such therapeutic loci are involved in therapy. The concealment of practices finds a spatial expression in the layout of most vital spot dispensaries. At a minimum, a curtain separates the space in which treatment is conducted from the gaze of even accompanying relatives, contrary to standard procedures in most Indian patient encounters (Halliburton 2002:1127). Ācāryas have been reported to utilize saris or bedcovers to shield their techniques from the eyes of others (see Langford 2002:214).

Even after a patient is saved from immediate danger, treatment is not complete. Continued treatment of vital spot ailments includes internal medication and, if required, bandaging along with repeated manipulations of limbs, joints, and muscles. Vital spot massage method (taṭavumugai) consists of stroking and rubbing the body, skin, muscles, joints, and tendons, and is almost invariably conducted by using medicated oils or ointments. Such medicinal agents are spread over the whole body or confined parts to penetrate the skin and vital spots. As in the emergency treatment described above, the aim of massage is to render a patient’s vital spots relaxed or slack. This means that both physiological structures and subtle, physiological processes return to a healthy condition.

Unless there is an immediate problem such as a fracture in the area to be massaged, application of pressure is generally quite strong, consisting of deep, intense massage strokes, which often cause patients to groan in pain. When I experienced this massage, I felt it impossible to relax my muscles, one of the prerequisites or positive effects expected by most Europeans and North Americans from massage. The force applied in vital spot massage, however, causes the recipient to wince or tighten muscles. Painful or pain-like sensations are frequently involved in both localized varmam stimulation and in massages; patients often experience these as current-like sensations. Ācāryas explain these as vital points being touched and released, triggering the circulation of pirāṇam vital force.

In massage strokes, ācāryas transmit their own pirāṇam energy to the person being massaged. A requirement for this is an extraordinary control over one’s own pirāṇam, which must be experienced and channeled by skilled practitioners and transferred through their own limbs into those of a patient. While directing vital force through massage techniques using their hands, feet, or other body parts, ācāryas not only manipulate their own pirāṇam but simultaneously perceive the vital force of the patient as well. Controlling one’s own pirāṇam allows for effective massage strokes.

Detecting a patient’s vital force facilitates an assessment of its circulation, by which the type and location of an impacted vital spot can be ascertained, as well as the kind of
massage required. Thus, pirāṇam and its control are important therapeutic and diagnostic tools. Even if patients moan under the pressure, this is no indication of wrong treatment in any way. Pirāṇam has to be activated in such treatments, and if a patient experiences current-like sensations or even pain, that is a sign of correct manipulation and therapeutic efficacy, not of the wrong treatment.

**When Not to Treat**

In emergency measures and massages, a patient’s pirāṇam, and with it the whole body, is supposed to become supple and relaxed. If this doesn’t occur, or if the body is regarded as too rigid for manipulation, massage and stimulation are not conducted. For instance, ācāṇs administer massages during the morning and early afternoon but not in the late afternoon or evening. During these times, bodies are said to be too rigid to receive massages, hence patients are advised to return either the next morning or after three days. A patient’s body can also be regarded as too rigid regardless of the respective time of day. Such a state may be due to a functional (tōcam) imbalance, which may render a body rigid; in this case, manual therapies are avoided. Instead, medical preparations, mainly decoctions (kaśāyam), are given to patients, who are advised to return only after consuming them and observing dietary prescriptions (pattiya) for a number of days. Because of the relaxing effects of medicine and diet, the patient’s body is then ready to be massaged.

Patients normally expect massage, are unaware that the ācāṇ regards their body as too rigid to apply it, and are thus frequently frustrated if they have to forego it. Because patients perceive vital spot therapy chiefly as a form of manual therapy, they connect much of its efficacy to an ācāṇs’ hands and manipulations—to their “healing touch,” or, literally, to their “lucky hands,” kairāci. Being sent off without having received a massage often disappoints patients, who plead with ācāṇs to relent and provide one. To one such patient, Velayudhan ācāṇ explained:

Velayudhan: You must understand that I cannot massage you now. We have to treat your stiff nerves first. Only after that will I massage.
Patient: But can’t you massage me just a little bit now?
V: No, I can’t, that’s what I’m telling you. (…) Look, there’s nothing I can give you except decoction, which you must take for three days. After that your body will be ready for massage.
P: But if you would just apply some oil, wouldn’t that be helpful?
V: No! Won’t you listen? Take the medicine first. Massage would create problems. I’m giving medicine first, massage only after three days. If there is anyone who treats you otherwise, then he’s an idiot, who doesn’t know varmam. Take the decoction and come back after three days.

**Naming the Secret: Vital Spots and Biomedical Terminologies**

Despite or rather because of the secretive behavior of ācāṇs, patients often seek ways to comprehend and label what ails them. One young man, for example, having been unsuccessfully treated by a variety of practitioners and medical systems, decided to consult Velayudhan ācāṇ for an ailment from which he had been suffering for several years. The symptoms included painful coughing and a constantly blocked nose, making his breathing difficult. After examining the patient’s pulse, Velayudhan pronounced that it was a vital spot ailment and therefore treatable. Relieved, the patient enquired about the name of his disease. Shaking his head, the ācāṇ replied this simply was varmam. Unsatisfied with this and
mistaking me for a biomedical professional, the young man asked me to explain his disease. I was unable to do so, and Velayudhan attempted to console the patient by attempting to describe how pirāṇam inside his body was obstructed. The patient was apparently not satisfied with this, and continued consulting me, asking, among other things, whether this was a “sinus problem.”

This case highlights several aspects: It attests to the fact that many patients turn to vital spot therapy as a last medical resort for chronic ailments that have not been cured by biomedical treatment. Nevertheless, the patient, unsatisfied with the diagnosis of varmam, had reverted to biomedical categories. It appears that some ācāṅs recognize this and employ the lay biomedical language desired by their patients or promote their practices in biomedical terms.

With regard to ayurveda in urban India, Harish Naraindas has noted that “efficaciousness, and the very premises of the dialogue, are framed by the language of biomedicine or some pidgin version of it” (2006:2662). There is an increasing deployment of biomedical terminologies to name vital spot ailments and supposedly to promote related practices. Signboards of dispensaries depict lists of ailments treated by practitioners, often including the disease categories of biomedicine instead of, or in addition to, Tamil terms. Even Tamil terms are often simple translations of biomedically defined diseases. These translations may be an attempt to provide options of verbalized explanations of vital spot ailments and treatments.

Such labeling of what is otherwise seen as to be kept concealed in biomedical terms is aimed at patients who seek to find alternative explanations of varmam than “that which is hidden,” or secret. Moreover, in a field of diversified health care practices in India today, generally termed “medical pluralism,” the dominant frame of discourse, credibility, and legitimacy appears to be that of biomedicine and of its language (see Baer et al. 2003:329). This dominance is visible in biomedical nosologies, through which patients try to gain agency and access to what their healers do. At the same time, patients partly subscribe to and perpetuate this dominance by adopting references understood in scientific and popular discourse, and by framing what they do in (what they understand as) biomedical terms.

This case is also interesting as it points to patients as important driving forces in an attempt to produce a correspondence between biomedicine and other therapeutic approaches and in translating one system into another. Previously, scholars have not acknowledged the role of patients to the same degree as they have emphasized the agency of professionals in this regard. It is also intriguing to note that a patient receiving treatment from an exponent of a form of health care described as empowering its patients seeks answers from biomedicine, the therapeutic approach sometimes criticized as disempowering its patients. This case also cautions against perceiving biomedicine as a somewhat homogeneous practice or system. In fact, what is generally described as biomedicine, and thus deliberately or unconsciously unified, may consist of widely divergent practices, techniques, and notions by professionals and nonprofessionals the world over (see Lock and Nguyen 2010; Mol 2002).

A Somatic Mode of Attending to Ailing Bodies

Manual forms of therapy, though arguably underrepresented in the literature (Oths and Hinojosa 2004:xiii), have been described as a nonverbal, bodily engagement with ailing patients’ distress (Hinojosa 2002, 2004a, 2004b; Walkley 2004). Such a mode of healing parallels what Csordas, drawing on Merleau-Ponty (1996 [1962]), calls “somatic modes of attention,” which he defines as “culturally elaborated ways of attending to and with one’s body in surroundings that include the embodied presence of others” (1993:198; see Csordas 1990, 1994).
Acknowledging the somatic modalities of attention and perception in healing encounters, Servando Hinojosa describes how his informants, Maya bonesetters, physically engage with their patients. They diagnose and treat using their own bodies, thereby achieving direct, corporeal links with their patients. Maya bonesetters describe their healing knowledge as located in their hands and claim that their bodies discover disorders by communicating with the bodies of others (Hinojosa 2004b:265). Since the related knowledge is located in the bonesetter’s hands, however, it is not subject to verbalization (Hinojosa 2002:27). Diagnosis and treatment hence are a “body-based potentiality” (Hinojosa 2004b:265), as patient’s physical ailments are identified only via the bonesetter’s body.

The diagnostic and treatment modalities of vital spot therapy present a parallel case: Ācāṅs make use of manual techniques, with which they physically engage with their patients’ bodies. Their incorporated skills appear to be tacit knowledge; a type of knowledge that, according to Michael Polanyi, is a nonlinguistic form of knowledge that “indwells” the body but cannot be verbalized, and which is thus opposed to explicit knowledge, that is, information which can be written down or explained (1967).

Maya bonesetters often have “bodily empathy” (Hinojosa 2002:28) with patients because they have suffered from similar ailments as their clients. According to Hinojosa, bonesetters who coexperience their patients’ conditions are better equipped to respond to bodily suffering. Elisabeth Hsu has contested the widespread biomedical explanation of the efficacy of pain inflictions as counter-irritation (2005). According to her, the infliction of acute pain in Chinese acupuncture techniques creates a social and physical connectedness between patient and healer through sensory attentiveness, which can be of therapeutic value.

The observation of the body as a basis for diagnosis and treatment and of a sociality created through pain infliction holds also true for varmam therapeutic practices. This is apparent from the induction of generally high pressure, triggering pirāṭam force and causing pain in turn—strikingly similar to the painful yet desired effects caused in acupuncture needling (Hsu 2005:78–79). In general, when Ācāṅs manipulate spots, acute pain is caused, which, combined, with its abating and the ongoing care by practitioners, may be acknowledged to create a physical and social link between patient and healer. Voluntarily enduring pain at the hands of someone else premises trust, which allows for the manual therapies to be administered in the first place. Seen in this light, Ramachandran, the practitioner who, when questioned regarding his methods, had sent away a patient, may not have acted merely out of an offended ego but because such questioning had jeopardized his treatment.

Ācāṅs acknowledge that they do, indeed, often refuse or are unable to tell their patients the names of particular ailments, the position or importance of vital spots, or the forms of therapy they will use. To characterize these patients as knowing, emancipated, or active can be misleading. However, Ācāṅs pay somatic attention to their patients’ bodies, especially to pirāṭam circulation, and this eludes explicit verbalization.

Reflecting on how to find a way out of the dichotomy between the knowing subject and objects that are known in medical interventions, Mol has suggested that it would be beneficial “to spread the activity of knowing widely” (2002:50). Instead of talking about subjects knowing objects, she suggests talking about enacting reality in practice, a move that circumvents granting doctors or patients subjectivity or objectivity, activity or passivity. In the case of vital spot medicine, such an analytic approach includes, among others, acknowledging the reciprocal and interactional processes of Ācāṅs’ somatic attending to patients and their ailments.
Conclusion

Although damage to vital spots causes imbalances and disease, health can be restored by therapies addressing the same loci. However, this and other intriguing manual-healing modalities have been chronically underrated or misunderstood in scholarly representation. Moreover, touching in medical encounters and manual forms of therapy are much devalued and are one reason for the comparably lower status of such practitioners vis-à-vis physically uninvolved physicians all over the world (Hinojosa 2004a, 2004b).

Human contact in medical settings has been reported to be particularly deprecated, and body workers, nurses, and manual practitioners are often merely allowed for auxiliary status, not for medically authoritative opinions (Van Dongen and Elema 2001). One reason for this might be the physical nature of manual medicine, which may impede verbal and scholarly description on the one hand, but which can provide for a particular healing relationship between practitioner and patient on the other. As I have discussed here, manual medical practices such as vital spot therapy allow for a reconsideration of the concepts of patient- and physician-agency and the nature of healing.

Some have argued that biomedicine alienates patients from their ailments, from the system of treatment, from their physicians, and from understanding or contributing to treatment processes. But are patients of other forms of health care emancipated and actively involved in the medical proceedings? And is it legitimate to assume biomedicine to be a somewhat homogeneous entity and to lump together hugely diverse forms of health care? Examination, diagnosis, and treatment of vital spot therapy are secretive processes. Neither diagnostic insights, disease categories, nor aspects of treatment are shared with patients. Ācānś claim to heal the “hidden”; varmam loci are not detectable by sight or modern imaging devices, but are only graspable by an experienced practitioner. This projects the romantic image of the Oriental physician—gentle and understanding—on the one hand, and of the corresponding patient—active and involved—on the other. Thus, the idea that the patients of (some) indigenous medicines are knowing, active, or emancipated is shown to be more ideological than actual.8

Active patients of indigenous or alternative medicines may be a cliché, as may be the idea of the passive patient of biomedicine, bereft of autonomy. The fact that such clichés fail to distinguish the many different kinds of alternative medicine, and assume that biomedicine is one monolithic entity, should alert us to the fact that they are rhetorical, not descriptive. It is neither justifiable to speak of biomedicine nor of indigenous, traditional, or even complementary medicine as generics when we know that these therapeutic ensembles vary from one geographical/cultural area to another concerning medical practice, users and patients, social policies, cultural practices, and so on.

Moreover, the active subject/passive object binary exhibits a body–mind dichotomy with a strong mentalist bias as conscious decisions, plans, or the resistance of patients and healers tend to be emphasized, whereas somatic circumstances, intersubjective, and interactional healing procedures—conditions that transcend the actual healing encounter, but nevertheless structure its proceedings—are neglected.

The diagnosing/treating body of the ācān and the diagnosed/treated body of the patient allow for a more precise reflection of the particular type of agency involved: Seeing the body as body-cared-for and as body-caring at the same time (see Van Dongen and Elema 2001:150). The seat of this agency, both patient and practitioner agency, is the body. As argued by Marcel Mauss, the body is at once object, tool, and agent (1934). The mode of connection between all, and the object and subject of procedure is touch. Although it has been argued that “the distinction between touching subject and touched object blurs” (Mazis 1971), this should not lead to believe that there are no distinct agencies of healers and patients in
vital spot medicine. As in other forms of healing, these are almost always asymmetrical and often shaped by influences outside of the therapeutic encounter (such as health policies, licensing, and registration laws, etc.).

All vital spot techniques depend on highly intricate corporeal skills of practitioners, but also on the patients’ physical presence. This does not mean, however, that vital spot therapy empowers patients or that it is an egalitarian exchange. There are distinct hierarchies involved. These are accentuated by specific techniques and diagnostic insights that ācāryas (sometimes deliberately) withhold from patients and by the fact that practitioners often (have to) go against the wishes of patients, such as when pain is an indication of successful therapy or when ācāryas abstain from treating. As this article shows, healing may not always involve will and intellect of patients (or that of healers), but this need not lead to the conclusion that patients are unknowing, passive objects. Rather, as the analysis of diagnosis and therapy of vital spot ailments highlights, healing may take place to large degrees on somatic, multisensorial, and preconscious, nonverbal levels.

In the case of vital spot therapy, curing can be described as situational: This is seen in the diagnostic techniques, which in vital spot medicine are highly dependent on individual cases and on the specific situation of any ailment and patient. Curing is processual, as practitioners are not so much concerned with a general category, but with the state or process of an ailment, which drive the therapy. Curing is a somatically reciprocal intervention, as highlighted by most diagnostic and therapeutic aspects of vital spot therapy, drawing as it does on ācāryas’ incorporated skills, tactility, and manual techniques and patients’ physical presence and compliance. None of this necessarily diverges from other forms of health care, but it is more informative than analyzing allegedly opposing and distinct agencies of physicians and patients.

Furthermore, as we see at the instance of naming varmam in biomedical terms and nosologies, such agencies can hardly be seen as isolated from broader phenomena such as the asymmetrically structured field of healthcare in India, which appears as dominated by the credibility and language of biomedicine. We therefore need to understand subjectivity and agency as always socially embedded processes of intersubjective experience (Kleinman and Fitz-Henry 2007).

As this article shows, this applies to the agencies of patients and physicians as well. Taussig has emphasized the intersubjectivity of patient and healer: “Health care depends for its outcome on a two-way relationship between the sick and the healer. Insofar as health care is provided, both patient and healer are providing it” (1980:10). The case of manual medicine, in general, and of varma maruttuvam, in particular, draws attention to this interactive characteristic of curing as much as to its situational, corporeal, and processual aspects.

Notes

1. Original terms, reproduced in italics, are transliterations from Tamil, except where noted otherwise. Data for this article were gathered throughout 2009 and 2010 using ethnographic research methods of participant observation and interviews combined with apprenticeship learning of varma maruttuvam, as part of a doctoral research project funded by the German Academic Exchange Service (DAAD).
2. For an account of the relationship between medicine and martial art in varma maruttuvam, see Sieler (2012).
3. According to Taussig, the social relations that are signified in disease symptoms are concealed within the realm of biological signs. Biomedicine, he argues, denies the human relations embodied in ailments and its symptoms, and thus neglects the subjectivity of patients by creating a “phantom-objectivity” of disease and of biomedicine (Taussig 1980:3).
4. At the time of the research, this amount was equivalent to about 30 US$.
5. The etymology of marman, the ayurvedic counterpart of vulnerable loci of the body, substantiates this argument (Wujastyk 1998:158).
6. The buffalo is the mount of Ėmañ (Sanskrit Yama), the god of death.
7. Or for a generic representative of Western concepts of health (Nichter 2008:169).
8. Some of the concerned studies are postcolonial ideological positions and should be analyzed as such.

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