Self-fashioning of the Hereditary Siddha Practitioner

Semantic Structure and Structuring Conditions

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ABSTRACT

This article examines issues related to competition within the domain of Siddha medicine (*citta maruttuvam*), that is, Tamil medicine. It focuses on the tension and co-constitution of the figure of the hereditary Siddha practitioner and the college-educated Siddha practitioner. Based on ethnographic interviews conducted in South India, it analyzes how the figure of the hereditary Siddha practitioner is semantically delineated in the aftermath of the formal professionalization of Siddha medicine. Based on the assumption that practices of self-representation and broader social structures form a constitutive relationship, it discusses the interlocutors' accounts as semantic positionings in a 'strategic action field' (Fligstein/McAdam 2012). Accordingly, the article suggests that the interlocutors' distinct self-fashioning, especially their appropriation and fusion of religious and scientific semantics, be conceptualized as a strategic improvisation that establishes and ensures them a favorable position in this particular social field.

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1 INTRODUCTION

Siddha medicine (*citta maruttuvam*) is a medical system mainly practiced in the Tamil-speaking areas of South India.[1] According to emic accounts by contemporary Siddha practitioners, the medical system is of divine provenance, having been discovered by the god Śiva and revealed by him to the siddhars (*cittarkaḷ*), "the ancient supernatural spiritual saints of India"[2], who in turn introduced the Siddha knowledge to the human realm.[3] Today, Siddha medicine is recognized by the Indian government as a traditional Indian medical system and has been integrated into the public health service. In the late colonial period and in the context of the policy of "state-sponsored medical pluralism" (Sujatha/Abraham 2009: 35), Siddha medicine underwent a process of formal professionalization along "modernist lines" (Habib/Raina 2005: 74). This process entailed the introduction of a standardized college education modelled on the biomedical paradigm, the reworking of Siddha medical knowledge in accordance with scientific principles, a differentiation between qualified and non-qualified practitioners through registration and official certificates such as the Bachelor's in Siddha Medicine and Surgery (BSMS), and the regulation of Siddha medical practices, especially in the production of pharmaceuticals (cp. Hausman 1996; Sébastia 2012a, 2012b;

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1 In accordance with the convention in English academic publications, I use the Sanskrit term *siddha* rather than Tamil *citta* to refer to the medical tradition. Furthermore, following conventions in English publications, I use *siddhar* and not the Sanskrit *siddha* or Tamil *cittar* to refer to the alleged authors of the Siddha literature and the founders of Siddha medicine. A further note on transliteration: Tamil terms are transliterated according to their Tamil forms. However, terms which are more commonly used in their Sanskrit versions, I have transliterated according to the Sanskrit spelling (e.g. *gurukula* instead of *kurukulam*, *doṣa* instead of *tōcam*, *śāstra* instead of *cāstiram*, *śiva* instead of *civaṉ*). Plural forms of Indian terms are marked by the suffix –s instead of the Tamil plural suffix *-kaḷ* (e.g. *pañcapūta*s instead of *pañcapūtaṅkaḷ)*. I render place names and personal names in their usual English spellings.

2 http://www.siddhavaidyam.com/Origin_of_SiddhaMedicine.html, August 18, 2017.

3 For scholarly work on the Siddhars, see White 1996; Venkatraman 1990; Zvelebil 1973, 1974, 1996.

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Sieler 2015; Weiss 2009). The formal professionalization of Siddha medicine led to the establishment of a secularized institution, which I refer to in this article as "the college institution." This professionalization also led to the appearance of a new figure in the medical field, whom in this article I call "the college-trained practitioner." The college institution is sufficiently powerful to sanction what constitutes genuine Siddha medical knowledge and Siddha medical practice and to define the criteria for occupational closure. Moreover, it is in a position to undermine the authority of the previous authoritative institution, which I call "the *gurukula* institution."[4]

This article looks at a particular figure that has emerged under these changing social conditions and that has become effective in opposition to the college-trained practitioner. I refer to this figure as "the hereditary Siddha practitioner." Hereditary Siddha practitioners depict themselves as representatives of the gurukula institution, which, they claim, has preserved the "real" Siddha knowledge, the "divine science"[5], and which has transmitted this knowledge within lineages (paramparai) of physicians from teachers to initiated students until the recent establishment of college education and the mainstreaming of an altered version of the siddhars' original knowledge. On the basis of self-descriptive accounts of seven contemporary Siddha practitioners who identify with the figure of the hereditary practitioner, the article analyzes how my interlocutors frame the figure of the hereditary practitioner.[6] The article examines the self-fashioning of the hereditary practitioner in the current medical landscape, as well as the fashioning of the traditional Siddha medicine, that is, following Habib and Raina (2005: 76), of the "contemporary practitioners' traditional medicine." The term "self-fashioning" has been chosen to emphasize the strategic orchestration involved in the construction of the figure of the hereditary Siddha practitioner. In adopting the term, I aim to highlight the proposition that my interlocutors' self-

4 A *gurukula* is traditionally a school where the disciples live together with their teacher.

5 http://www.devavidya.com/vision.html, September 29, 2016.

6 The term "framing" features prominently in the social sciences in areas as different as ritual theories (Goffman 1974) and media theories (Gamson 1985). However, I use the term in its everyday meaning of "delineating," "describing," or "laying out," without reference to any particular academic debate.

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representations are consciously fabricated within the structuring framework of their social position.[7]

The first part of the article describes how the figure of the hereditary Siddha practitioner is semantically fashioned by examining the construction of the symbolic boundaries between this figure and its "constitutive outside" (Hall 2003: 17, emphasis in the original). Special attention is given to the application of religious semantics and the emphasis on tradition in the self-descriptive accounts of my interlocutors. In the second part, the article discusses the social structures within which the figure emerges and suggests interpreting the specific self-fashioning as a semantic positioning in a "strategic action field" (Fligstein/McAdam 2012). The article engages with Bourdieu's stance that the "construction [of social reality] is not carried out in a social vacuum but subjected to structural constraints" (Bourdieu 1989: 18). It argues that the figure of the hereditary Siddha practitioner emerges within the contextual conditions of the professionalization of Siddha medicine and that the college-trained practitioner creates the foil against which this figure becomes meaningful. Consequently, the article does not focus on the competition between Siddha medicine and biomedicine, but examines issues related to competition within the domain of Siddha medicine itself. In doing so, it fills a gap identified by the historian of religion, Richard Weiss (2009: 201). The article argues that, under conditions of the professionalization of Siddha medicine, the religious semantics and the emphasis on tradition appear as a mode of cultural production which becomes effective in the self-fashioning of the position of the hereditary Siddha practitioner. The replacement of the gurukula institution by the secularized college institution favors, so to speak, the appropriation of religious argumentation and the rhetoric of tradition as a means whereby a distinct social group attempts to provide its knowledge with authority and to attain a different status in the social field.

7 The term "self-fashioning" loosely reflects the term "objective self-fashioning" coined by the medical anthropologist Joseph Dumit. While Dumit uses the latter term to analyze how the understanding of the biological self, the "person, body, brain, and mind" (2010: 368), are actively and continually produced, I use the term "self-fashioning" to point to the ways in which a position in a social field is produced.

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2 ETHNOGRAPHIC MATERIAL: SAMPLE AND ANALYSIS

This article is based on material generated in the exploratory phase of my PhD project, which stretched over a period of four years (2014 to 2018).[8] The main sources for this article are informal conversations and ethnographic interviews with Siddha practitioners conducted between December 2014 and February 2015. Ethnographic interviews are unstructured and open interviews which do not follow a set pattern but respond to the particular situation in which they take place. Also, they typically resemble an everyday conversation, yet without the back and forth characteristic of this type of social interaction (Schlehe 2003: 72). A further source are the webpage texts of my interlocutors. Furthermore, the tool of ethnographic observation was used during fieldwork in order to see what people do and what kind of infrastructure they use for their actions (cp. Bernard 2011). However, since this article is mainly concerned with semantics rather than practice, the data I generated through observational techniques come into play only marginally in the present article.

The sample consists of Siddha practitioners who present themselves as hereditary Siddha practitioners. "Hereditary Siddha practitioner" is a term I introduce to capture and subsume the emic terminology I encountered in the field, such as "traditional *vaittiyar* (physician)" (Anbarasi), "traditional experts" (Prem Nath), "traditional practitioner" (Prem Nath), "*pārampariya* (traditional) doctors" (Surendran), "*paramparaiyāṉa vaittiyar* (hereditary practitioner)" (Kapilan) or "the real Siddha doctor" (Devanesan). I conducted ethnographic interviews with seven practitioners, six men and one woman (Anbarasi), one in Tamil (Kapilan), the others in English, or more precisely with English as the foundational language interwoven with Tamil, which proved to be the most convenient mode for conducting the interviews for everybody involved. All the interviews were conducted in the clinics of my interlocutors. The interlocutors share some basic socio-demographics. They are all around forty years old and live in towns in the southern Indian state

8 The doctoral thesis focuses on the intersection of Hindu guru organizations and Siddha medicine in present-day South India. The research was generously supported by the *University Research Priority Program Asia and Europe,* University of Zurich and funded by the Humer Foundation.

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of Tamil Nadu. The exception is Prem Nath, who lives in Kerala in an area populated by both Malayalis and Tamils. Prem Nath comes from a Tamil family, and the circumstance that he lives in Kerala does not make his situation different from those of the other interlocutors.[9] My interlocutors also share similarities with regard to their medical practice. They all run their own clinics (*vaittiyacālai*), and they all produce medical drugs (*maruntu*), which, as they state, are based on formulas inherited from their gurus. The clinics are small-scale settings, and my interlocutors cater to as many as forty patients a day. In all the settings, consultation is free of charge, but the costs of the drugs have to be covered by the patients. Apart from two practitioners (Anbarasi and Surendran) who run a business selling drugs to retailers, the drugs are exclusively dispensed to the practitioners' own patients. Moreover, my interlocutors share themes in their self-representation. They all state that they see their work as their duty to keep Siddha medicine from vanishing. They argue that the Indian government's recognition of their medical system and its integration into the public health sector has not benefitted Siddha medicine but rather has had adverse effects on it. The most important shared element in their self-representation for the argument I develop in this article is that they all identify with the hereditary Siddha practitioners and strongly distinguish themselves from college-trained practitioners. While they describe themselves as practicing Siddha medicine "the traditional way" (Devanesan), applying "the traditional method" (Surendran), and having "traditional knowledge" (Prem Nath), they describe the college-trained practitioners as practicing "modern" (Devanesan) or "regular" (Anbarasi, Surendran) Siddha medicine, and as going the "academic way" and following the "university model" or the "educational system" (Prem Nath). My interlocutors claim that they, on the contrary, learnt the "real" Siddha medicine outside modern college institutions with a guru. Three of my interlocutors (Prem Nath, Avalok, Rubendran) stated that they hail from Siddha physician families and that they studied with their grandfathers and fathers, whereas the other four interlocutors learnt Siddha medicine with a guru outside their family. One of my interlocutors (Kapilan) framed this distinction in terms of *karuvaḻi* and *kuruvaḻi*, that is, entering a *gurukula* by birth (*karuvaḻi*, the way of the embryo) or by initiation (*kuruvaḻi*, the way of the guru).

9 Prem Nath did not wish to be anonymized. The other interlocutors have been given pseudonyms.

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It should be noted, however, that, in addition to their training with a guru, my interlocutors have also earned certified medical degrees, a prerequisite to practicing medicine legally in contemporary India.[10] From an analytical point of view, the fact that my interlocutors earned certified diplomas makes their self-representation as non-college-trained practitioners appear contradictory. However, what is important for the argument I develop in this article is that, regardless of the certified diplomas which they hold, they fashion themselves as hereditary Siddha practitioners and distance themselves from practitioners who only learnt Siddha medicine in college and who do not have access to any other source of medical knowledge.

The method used in analyzing the data follows the paradigm of *theoretical coding* and the analytical method of *grounded theory* (cp. Glaser 1978). *Theoretical coding* is a reconstructive method that aims to identify concepts in the material from which more abstract categories are developed. These abstract categories serve as a tool with which to organize the material and present it analytically. The categories are derived from the analysis of the material obtained during fieldwork. The dominant categories in the material serve as the basis for the construction of the ideal type of the hereditary Siddha practitioner I discuss in this article. The ideal type is not identical with empirical types; rather, it is to be understood as a generalization of the dominant features that are present in my interlocutors' accounts.[11] My interlocutors show these features to varying degrees, which will be indicated in the analysis. As should become clear with regard to the limited size of the sample, this study is conceptualized as a case study which does not speak for a larger whole, yet which is a valuable means of exploring trends in a specific group and thus of diversifying the existing academic discourse. However,

10 Two of my interlocutors (Anbarasi and Surendran) have Bachelor's degrees in Siddha medicine (BSMS), one (Prem Nath) a Diploma in Siddha medicine (the older equivalent of the BSMS), one a Bachelor's degree in Ayurveda (Rubendran), and one a Bachelor's degree in homeopathy (Avalok). Two other practitioners have certificates issued by different Siddha associations, which do not count as legal documents allowing one to practice legally (Devanesan, Kapilan).

11 For a discussion of the ideal type versus the empirical type, cp. Kuckartz 1991. It would be revealing to test the ideal type that was developed on the basis of the seven cases in a next step using a larger sample in order to refine or confirm it.

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one should bear in mind that the conclusions are provisional and more research is needed to strengthen the arguments and make them more nuanced.

3 THE PROTAGONISTS: AN EMANATION OF THE FIELD

I conceptualize the figure of the hereditary practitioner not as my interlocutors' individual creation or *ad hoc* improvisation, but as a figure that emerges in a distinct social configuration. This view is expressed in Bourdieu and Wacquant's famous statement: "And we could say, following the formula of a famous German physicist, that the individual, like the electron, is an *Ausgeburt des Feldes*: he or she is in a sense an emanation of the field." (1992: 107, emphasis in the original) On this note, I suggest that the articulations of my interlocutors follow certain rules which are linked to the dynamics of their social field (Bourdieu/Wacquant 1992: 98). Furthermore, I understand the figure of the hereditary Siddha practitioner as a collective figure, the collective dimension resting on the construction of a sense of a larger community of hereditary practitioners, both synchronically and diachronically. This sense of community is established and reproduced by my interlocutors through the *articulation* of tradition. The synchronic community is expressed in the individual practitioner's identification with other, contemporary practitioners. The diachronic community is expressed in the linking of the individual practitioners with previous practitioners and in their self-locating in a lineage of hereditary practitioners. The crucial point is that the articulation of community allows multiple subjects to identify with the figure of the hereditary Siddha practitioner, a collective figure that transcends the interests and identity of the individual. This stance brings to the fore a pressing question: Which social configurations are constitutive for the emergence of the figure of the hereditary Siddha practitioner? What are the characteristics of the field from which this figure emanates?

The field in which my interlocutors are situated underwent far-reaching transformations in the late nineteenth and twentieth centuries that are still reflected in its current arrangement. Those transformations are too complex to meaningfully outline in a short synopsis. In the following, I will limit my attention to one distinct component of those transformations, namely the process of the formal professionalization of the medical profession. Broadly

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speaking, professionalization means turning an occupation into a profession[12], a process observable in many different occupational domains, medicine being just one among them, though it is often held out as "the canonical example" of professionalization (Ranganathan 2013: 903). Needless to say, the professionalization of Siddha medicine is a complex process that can only be sketched out in broad strokes here.[13] The process can be traced back to the late colonial period, and it continued into India's independence. The colonial administration and later the Indian government both took on a leading role in this process, yet it should be realized that associations of what were then called ISMs (Indian Systems of Medicine) and individual practitioners of ISM were also decisive actors (cp. Sébastia 2012b; Sujatha/Abraham 2009, who strongly emphasise this point). I will limit the following remarks to one scholarly position arguing that it is no historical coincidence that the professionalization of Indian medical systems coincided with the emergence of resistance to British colonialism.[14] This position is reflected in Last's statement that the professionalization of Indian medical systems was carried out "to rival those [medical institutions; NR] set up for 'cosmopolitan' (or 'Western') medicine by the imperial regime" (Last 1996: 385).[15] The development of professionalized Indian medical systems, be it Siddha medicine or others, reflects, so to speak, a dominated society's strategy to "establish parity with the hegemon" (Habib/Raina 2005: 69). Indian medical systems emerged as standardized, professionalized forms of medicine in a period in which India

12 Broman lists six criteria for a profession: "(1) specialized and advanced education, (2) a code of conduct or ethics, (3) competency tests leading to licensing, (4) high social prestige in comparison to manual labor, (5) monopolization of the market in services, and (6) considerable autonomy in conduct of professional affairs" (1995: 835).

13 I am not referring here to what Engler (2003: 450), with regard to Ayurveda, calls "rudimentary professionalization" at its very inception, but to professionalization which is closely linked to the development of a modern college institution.

14 There is a rich literature on the connections between nationalism, the construction of identities, and medicine; see, for example, Brass 1972, Hausman 1996, Langford 2002, Leslie 1976, Weiss 2009, Wujastyk/Smith 2008.

15 Another interpretation prioritizes the role of practitioners and students of IMS who wanted to improve their reputations and economic opportunities and thus aspired to adapt IMS to the dominant biomedicine.

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was engaged in what Weiss calls a "struggle to counter cultural imperialism" (2005: 175) and was forming a "national-cultural imaginary" (Langford 2002: 17) of the emerging nation state. Through the process of professionalization, Indian medicine was reified as a series of distinct medical systems, making it possible for them to challenge Western claims of superiority in general and to oppose the particular Western medical knowledge system to which the colonial state subscribed (Sujatha/Abraham 2009: 37).[16] While Ayurveda featured most prominently as the Indian counterpart to Western medicine and has received the greatest attention in both emic and academic debates, other Indian medical systems also emerged and were presented as superior alternatives to Western medicine.[17] These dynamics found expression in the "state-sponsored medical pluralism" (Sujatha/Abraham 2009: 35), which, at least normatively, recognizes and advocates non-biomedical systems and integrates them into the public health sector. The positive evaluation of Indian medical systems has continued and is visible in India's present medical landscape in the form of the Ministry of AYUSH (an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy), which promotes medical pluralism and is tasked with the role of protecting AYUSH medical systems.[18]

16 The term "Siddha medicine" appears for the first time in a government report of 1923, the so-called Usman Report. Before that, it was known as Tamil Medicine or Tamil Ayurveda (Sébastia 2012a: 166). Krishnamurthy (1984) also shows that Siddha and Ayurveda have only been treated as two distinct medical systems relatively recently.

17 On Ayurveda, cp. Langford 2002; on Siddha medicine, cp. Weiss 2009; for naturopathy in India, cp. Jansen 2016.

18 The Ministry of AYUSH dates back to the establishment of the Department of Indian Systems of Medicine (ISM) in 1969, to which homeopathy was added in 1995, when it became the Department of Indian Systems of Medicine & Homeopathy (ISM&H). It was renamed the AYUSH Department in 2003, and in 2009 Tibetan medicine was included. In 2014 it was given the status of an independent ministry. However, in spite of the promotion of medical pluralism, AYUSH medicines still receive only marginal support. This leads Priya to speak of "undemocratic pluralism" (2012: 104) and Naraindas, Quack and Sax (2014) of "asymmetrical conversations" between different medical systems. For the issue of inequality in accessing these medical services, cp. Broom et al. 2009.

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As Broman (1995: 835) points out, “specialized and advanced education” is one of the key criteria for distinguishing professions from other occupations. Professionalization involves a process of setting up a formalized and standardized education and training system. Retrospectively, the establishment of the School of Indian Medicine in Chennai in 1924 can be described as the starting point of this process, since it was the first college to teach Indian medicine (Ayurveda, Unani and Siddha) independently of Western medicine (e.g. Arnold 2000: 185; Bala 2007: 103).[19] The first college where Siddha medicine could be studied as a separate degree was only opened in 1964 in Palayamkottai, a town in Tamil Nadu (Sébastia 2012b: 4f).[20] The creation of what Broman calls “specialized and advanced education” (1995: 835) also involved the definition of an orthodox body of knowledge. This meant sanctioning what is considered valid and excluding what is considered invalid knowledge, a process which obviously led to the alteration of the knowledge base of the respective occupation (Ranganathan 2013: 925).

In the process of the professionalization of Siddha medicine, the teaching and transmission of medical knowledge was turned into a college course comprising a set canon of subjects and following a distinct curriculum and, as Sujatha points out, “distinct epistemic models of the body” (Sujatha 2011: 191).[21] Siddha medical training was restructured on the basis of a Western-style education and modelled along the lines of the biomedical curriculum, as is obvious from the length of the course, the distinction between undergraduate and postgraduate training, the subjects taught,[22] the setting of the teaching, and the way the students are examined.[23] This restructuring has had

19 Previously, in 1822, a Native Medical Institution was opened in Calcutta, which aimed at a hybridized form of the Western and Indian medical systems. It was closed in 1835 (Fischer-Tiné 2013: 35).

20 Today there are seven Siddha medical colleges in Tamil Nadu and one college in Kerala offering a BSMS degree. Six of them are private and the other two government institutions.

21 The curriculum of the 5.5-year college program was designed by the CCIM (Central Council for Indian Medicine), cp. http://www.ccimindia.org/siddha-syllabus.php, July 10, 2016.

22 The BSMS includes subjects such as biochemistry, microbiology, anatomy and physiology; cf http://www.ccimindia.org/siddha-syllabus.php, July 10, 2016.

23 Jansen shares a similar observation with regard to naturopathy (2016: 15).

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an effect not only on the form and content of Siddha medicine as a medical discipline, but also on the practice of the prospective practitioners.[24] I observed during my fieldwork that Siddha physicians who studied exclusively in the college setting often exhibit striking similarities to biomedical doctors: they wear white coats, are equipped with stethoscopes, and speak of metabolism, hypertension, and sugar levels in generic biomedical language; also, they are addressed by patients as "doctor" and hardly ever as *vaittiyar* or *maruttuvar*. Moreover, these practitioners often begin a consultation by checking the patient's blood pressure using a sphygmomanometer, but hardly ever assess the imbalance of the three humors (*mukkuṟṟam* or *tridoṣa)* of wind (*vātam*), bile (*pittam*), and phlegm (*kapam*) by sensing the patient's pulsation (*nāṭi paricōtaṉai* or *nāṭi pārttal*).[25] Also, they send their patients to take X-rays and blood tests in laboratories and prescribe drugs in the same manner as biomedical doctors. The drugs are colorful capsules and sealed tablets that look very much like biomedical drugs. Furthermore, the professionalization of Siddha medicine involved the establishment of scientific societies and associations that were founded as a means to create a platform for the exchange of medical knowledge and to institutionalize the scientific ideal of transparency.[26]

The Indian government played a decisive role in the creation of the new medical institution, which leads Sujatha and Abraham to speak of a "state-induced institutional development" (2009: 37). They write (2009: 40): "The establishment of various councils, national institutes and drug testing laboratories were direct outcomes of the recommendations made by various committees set up by the government." One of the major concerns of this "state-induced institutional development" was the testing and validation of drugs in accordance with biomedical standards. New regulations concerning the production of drugs were introduced. One of these regulations requires that drugs which are produced for sale on the pharmaceutical market have to be patented by the Office of Drugs Control and must receive a Good

24 Referring to these changes, Sujatha speaks of a process of "pharmaceuticalization" (2011: 193).

25 On sensing the pulse, cp. Daniel 1984: 115; cp. Sieler 2014: 325–326.

26 The establishment of scientific societies is a strong example of what Habib and Raina call the "routinizing [of] a new set of institutional practices that were elements of the modern research systems" (2005: 74).

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Manufacturing Practice (GMP) certificate (Sébastia 2012a: 178–179, 2015: 951). In order to obtain this certificate, the composition of the drug has to comply with the Drugs and Cosmetics Act (1940) and Rules (1945), which, as Sujatha and Abraham rightly state, subjects "the ISMs [Indian Systems of Medicine] to the political economy of the laboratory" (Sujatha/Abraham 2009: 40–41) and restricts the agency of the practitioner in the production of the medicine. The role of the government in the process of professionalization also becomes visible with regard to legal regulations concerning the requirements for the practitioners. One of these regulations is the Indian Medicine Central Council Act, introduced in 1970, under which only physicians with the required credentials have the authority to practice medicine (Payyappallimana/Hariramamurthi 2012: 284).[27] With the introduction of this act, holding an officially recognized certificate became mandatory to practice Siddha medicine legally, which delegitimizes other forms of knowledge transmission (Sébastia 2012b: 5).[28] Thus, professionalization introduced occupational closure on the basis of a requirement for formal qualification and created a group of professionals who are entitled to practice Siddha medicine legally and, *vice versa*, a group of practitioners who are excluded from the profession because they do not have the documents authorizing them to practice. These government regulations thus replaced other, informal mechanisms of occupational closure laid down by the *gurukula* institution, or, more broadly speaking, the government regulations did not reinforce the authority of the *gurukula* institution but undermined it. As will become clear in the following reconstruction of my interlocutors' self-understanding, it is this process of the formal professionalization of Siddha medicine that is constitutive of the emanation of the figure of the hereditary Siddha practitioner.

27 This act was preceded by several other registration acts, such as the Medical Registration Acts introduced between 1912 and 1919 in all the provinces of India (Hardiman 2009: 275).

28 Since 1977, the required certificate has been the Bachelor's degree in Siddha Medicine and Surgery (BSMS).

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4 THE FIGURE OF THE HEREDITARY SIDDHA PRACTITIONER

Using one of Bourdieu's phrases, the reconstruction of my interlocutors' narratives regarding their self-representation provided in the following section takes the form of "'an account of the accounts' produced by social subjects" (Bourdieu 1989: 15). It emphasizes especially how my interlocutors construct symbolic boundaries, that is, conceptual distinctions which social actors deploy to organize their social worlds (Lamont/Molnár 2002: 168). Investigating symbolic boundaries sheds light, as Lamont and Molnár remark, on "the dynamic dimensions of social relations, as groups compete in the production, diffusion, and institutionalization of alternative systems and principles of classifications" (ibid: 168). It is this dimension of social relations and the construction of classifications which is ultimately of interest here. The analysis of the construction of symbolic boundaries is divided into two sections. The first part focuses on the "*constitutive outside*" (Hall 2003: 17, emphasis in the original) in the accounts of my interlocutors. The argument formulated here is based on the common assumption that "all identity is differential identity" (Laclau 1995: 151) and that therefore the outside is constitutive of the identity concerned. The second part focuses on the appropriation of symbolic resources in the process of self-fashioning, such as conceptual distinctions or interpretive strategies. Special attention is given to the fusion of a religious and a scientific semantics in the self-fashioning of the hereditary Siddha practitioner and to the emphasis on tradition versus innovation.

4.1 The Constitutive Outside

My interlocutors distinguish the hereditary Siddha practitioner from three figures and their respective forms of medicine: the biomedical doctor, the Ayurveda practitioner, and the college-trained Siddha practitioner.

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4.1.1 The Biomedical Doctor as the Constitutive Outside

All my interviewees, apart from Devanesan, refer to biomedical doctors and biomedicine.[29] Their descriptions of biomedicine revolve around a small repertoire of topics on the basis of which they demonstrate Siddha medicine's alleged superiority over biomedicine. A dominant theme which runs through their accounts is the juxtaposition of biomedicine as a man-made invention and Siddha medicine as a "divine medicine" (Prem Nath, 31.12.2014) with a "divine origin" (Surendran, 16.1.2015). Regarding this matter, Prem Nath (31.12.2014) says: "It [Siddha medicine] is not invented by anybody else. Not ['by'] me, nor ['by'] my ancestors nor by anybody else."[30] It has, he states, a "divine source." My interlocutors describe biomedicine, by contrast, as a science developed by human scientists who gradually come up with new technology and new medical formulations that only have a provisional validity and will eventually be overwritten by new inventions:

> "Then the next thing, in allopathy they find out some combination. Then, after ten years, what they say is, 'this medicine is not good for this problem, so please avoid this medicine.' But in Siddha medicine what was written three thousand years back, still I am doing that same medicine. And three thousand years from now, my successor will still be doing this medicine. How miraculous it is!" (Anbarasi, 6.1.2015)[31]

Another issue which comes up with regard to biomedical drugs is the nature of the drugs themselves. My interlocutors share the view that biomedical drugs are made of chemicals. Anbarasi states, for example: "All are chemical. Not natural. It is a pity what is going on." (6.1.2015) Siddha medical drugs, on the other hand, are held to be composed of natural substances and

29 While my interlocutors speak of "allopathy," "modern medicine" or "English medicine," I will use the term "biomedicine," which is a common term in academic literature.

30 Mr. Prem Nath practices Siddha medicine in his own clinic in Thiruvananthapuram. He hails from a hereditary Siddha family with a lineage dating back in history before the Common Era. He has a Diploma in Siddha medicine.

31 Mrs. Anbarasi practices Siddha medicine in her own clinic in Coimbatore and runs a business selling drugs to retailers. She has studied in a *gurukula* and has a Bachelor's degree in Siddha Medicine and Surgery.

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thus to be in tune with nature. The trope of Siddha medicine's harmony with nature is prominent in all my interlocutors' accounts, and it is also visually present on their webpages, as well as in the leaflets and brochures they provide through icons such as fresh leaves, flowers, roots, and images of manual tools for the production of drugs. Biomedicine appears in all the accounts (except in Devanesan's) as a counter-example to the naturalness of Siddha medicine. The chemical substances of biomedical drugs are considered "poison" (Anbarasi, 6.1.2015) and are seen as the source of the side effects (pakkaviḷaivu) of these drugs.[32] The characterization of biomedicine as a medicine with side effects is present in all my interlocutors' accounts (again not in Devanesan's). Kapilan states: "[…] the problem is the side effects caused by this treatment. One disease will disappear with the medicine, and another will arise in another part of the body because of the medicine."[33] (12.1.2015) Siddha medical drugs, on the other hand, are described as drugs which do not have any adverse effects—provided they are made in the right way—because, as stated above, they are believed to be made from natural substances, or, as my interlocutors also say, they are made in accordance with the pañcapūtam theory. This theory comprises the view that the micro- and macro-cosmos are both constituted of the five elements—earth, water, fire, air, and space—and that accordingly everything that we take in should only comprise these pañcapūtas.

"So we are using the herbs to prepare the medicine. With the help of *pañcapūta*s only we are treating the patients. So the herbs have *pañcapūta*s, our bodies have *pañcapūta*s. […] But allopathy medicines are not made by *pañcapūta*s. Or were they made by *pañcapūta*s? No! Allopathy is made by a company. They mix up chemicals and make them into a medicine. That is all." (Anbarasi, 6.1.2015)

With regard to biomedical drugs, my interlocutors raise another aspect, namely the curing mechanisms. All my interlocutors (except Devanesan)

32 This claim can be taken as a reversal of the accusations with which their "guild" is often confronted today: accusations of quackery and of causing harm to people.

33 Mr. Kapilan practices Siddha medicine in his own clinic in Pollachi. He has studied in a *gurukula* and has a certificate in Siddha medicine issued by a Siddha association.

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express the view that biomedicine treats the symptoms while Siddha medicine treats the root cause of the disease.

"And in allopathy, I am not blaming it, but in allopathy they are only treating the symptoms. But we are not giving any treatment to the symptoms. We only focus on the root cause. So when the root cause will be gone, automatically the problem will subside." (Rubendran, 6.1.2015)[34]

4.1.2 The Ayurveda Practitioner as the Constitutive Outside

Ayurveda practitioners and Ayurveda medicine appear in all my interlocutors' narratives, yet only on the periphery. This is a surprising finding, since, during the Tamil revivalist movements of the twentieth century, Ayurveda figured as the quintessential "other" of Siddha medicine (cp. Weiss 2008, 2009). On the basis of this observation, and with Richard Weiss in mind, I am inclined to translate this finding as an expression of a shift in boundary-making.

It is noticeable that, when my interlocutors refer to Ayurveda, they do not emphasize the differences between Siddha medicine and Ayurveda in the first place but rather accentuate their similarities. My interlocutors stress that the two medical systems are both Indian, that they share diagnostic procedures (Rubendran), medical formulas (Rubendran, Anbarasi, Surendran) and concepts about the constitution of the body (Devanesan, Surendran), and that they mainly differ in terms of language (Tamil for Siddha medicine and Sanskrit for Ayurveda). However, and this should not be overlooked, at the same time they subordinate Ayurveda to Siddha medicine. Some of my interlocutors (Surendran, Avalok, Rubendran) do this by arguing that Siddha is the older and original medicine and that Ayurveda is just a translation of Siddha medicine into Sanskrit. Most often, however, Ayurveda is subordinated to Siddha on the basis of the substances used for the medical drugs. Four of my interlocutors describe the use of metals and minerals as one of the quintessential and unique characteristics of Siddha medicine, while they describe

34 Mr. Rubendran practices Siddha medicine in his own clinic in Coimbatore. He hails from a hereditary Siddha family with a lineage going back fifteen generations. He has a Bachelor's degree in Ayurveda Medicine and Surgery.

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Ayurveda as herbal-based medicine, which they consider less effective and not fit for treating chronic and severe diseases.

"And this is another important thing: Siddhars did not only prepare medicine with herbs, but also metals and minerals and salts, byproducts from the sea, shells, all kinds of shells […]. So our Materia Medica is not only herbs, but also metals-medicine, minerals-medicine. If we look at the books, it is alchemy work. In the whole world until now, nobody did that, nobody else can do it." (Anbarasi, 6.1.2015)

On the basis of the same argument, Prem Nath describes Ayurveda as "human medicine" (*maṉuṣavaittiyam)* and Siddha medicine as "divine medicine" (*tēvavaittiyam)*. He classifies Ayurveda as *maṉuṣavaittiyam* because it is herbal-based medicine that does not require higher knowledge for the production of drugs. Conversely, he argues that Siddha medical drugs can only be produced by applying the "divine method"[35] for the purification of metals and minerals, that is, the method that was discovered by the siddhars, which makes Siddha medicine *tēvavaittiyam*.

4.1.3 The College-Trained Siddha Practitioner as the Constitutive Outside

The figure of the hereditary Siddha practitioner is primarily framed against the figure of the college-trained Siddha practitioner. The latter is, so to speak, the main "constitutive outside" of the hereditary Siddha practitioner in my interlocutors' accounts. In my interlocutors' view, college-trained practitioners are Siddha practitioners who studied exclusively in a modern college setting. Prem Nath describes them as "university people" or "academic people" who follow the "university model." Alternatively, they are depicted as practicing the "modern" (Devanesan, 5.2.2015) or the "regular" (Anbarasi, 6.1.2015; Surendran, 16.1.2015) Siddha medicine. The college-trained Siddha practitioner is constructed as the negative other of the hereditary practitioner with reference to a number of issues, all of which can be interpreted as expressions of my interlocutors' perceived struggle to have their knowledge approved and of the question of what constitutes genuine Siddha

35 http://www.siddhavaidyam.com/Principles_of_SiddhaMedicine.html, August 18, 2017.

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medical knowledge. Furthermore, my interlocutors share the view that the establishment of the college institution has not contributed to the preservation of the medical tradition but, on the contrary, poses a danger to its continuation. Kapilan encapsulates this view by stating that the college-trained practitioners are "tweaking the original concept" of Siddha medicine and that "therefore there is a danger that people who are bookish are destroying the real practical tradition of Siddha" (12.1.2015). This leads him to speak of the "false institutionalization of Siddha medicine," which amounts to the "systematic destruction of Indian traditional culture."

My interlocutors share the view that one cannot learn the real Siddha medical knowledge in colleges because colleges are not in possession of it. Prem Nath says that colleges do not have access to the "key books," that is, to the knowledge revealed by the god Śiva, because this knowledge is kept within the families of hereditary Siddha practitioners. The "proper knowledge" can therefore not be acquired in college. On Prem Nath's webpage it says:

> "Today there are recognized Siddha Medical Colleges [which] run under the government universities where Siddha medicine is taught. But they are running the course with average syllabus [compared] to the knowledge of Traditional Vaidyas. In Siddha Vaidyam […] many toxic drugs and heavy metals are [used] for manufacture [of] bhasmas and chindooras. [Lack] of proper purification will cause major draw-backs in health. Traditional Siddha Physicians are doing effective purification process. But they hide it as traditional secret and transfer [it] only to the next generation."[36]

As this quote shows, my interlocutors are mainly concerned about knowledge that pertains to the production of Siddha drugs that involves the purification of the substances, that is, the transformation of metals and minerals into medicine. In their view, this purification process is the unmistakable characteristic of Siddha medicine and an essential element of Siddha practice. Rubendran states that he learnt the production of medicine from his father, which is the only way to master that practice. And Surendran too states that in college you can only learn how to become a Siddha physician,

36 http://www.siddhavaidyam.com/siddhavaidyam.html, August 18, 2017.

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you cannot learn how to produce medicine, because, he states, "[f]or that we need a guru."[37]

My interlocutors do not just speak of the omission of certain elements of Siddha knowledge, but also of the remaking of Siddha knowledge through the merging of traditional Siddha knowledge with biomedical knowledge. With regard to this remaking, Prem Nath mentions the mixing of modern anatomy, physiology, and pathology books such as Chaurasia's *Anatomy* or Hutchinson's *Clinical Methods* with the classical Siddha literature. Two of my interlocutors (Devanesan, Avalok) also mention the introduction of biomedical diagnostic techniques into Siddha practice, such as measuring blood pressure, taking blood tests, and doing X-rays, instead of assessing the imbalance of the three humors (*mukkuṟṟa* or *tridoṣa)* through the *nāṭi pārttal* (examination of the *nāṭi*).

"The *vaittiyar*s who lived here, they healed people in this way. They would not take a stethoscope and check, no […]. But now everybody has different techniques. […] I cannot criticize that. I am only telling you the way how I prefer it." (Devanesan, 5.2.2015)[38]

Furthermore, Devanesan points to the change in how the medicine is dispensed. He says that the "modern practitioner" prescribes manufactured medicines which come in capsules, tablets and syrups, and he adds:

"How can you trust that modern medicine? I cannot trust that modern medicine. They are putting preservatives. Preservatives are damaging the liver! So why would we do it like that? This Siddha medicine is meant to be taken naturally. This is how the divine gave it." (Devanesan, 5.2.2015)

With regard to changes to Siddha medical knowledge through the establishment of a college education, Prem Nath (31.12.2014) speaks of the

37 In this respect, some of my interlocutors mention the omission of formulas for the production of key drugs in Siddha medicine such as *muppū* or *navapāṣāṇam*, which are thought to cure all diseases and even to bestow immortality.

38 Mr. Devanesan practices Siddha medicine in his own clinic in Pondicherry. He has studied in a *gurukula* and has a certificate in Siddha medicine issued by a Siddha association.

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consolidation of a “fake route”: “[…] unfortunately I want to say that the new government policies like AYUSH and medical universities and everything is going on a fake route.” In his view, the siddhars transmitted to humanity a complete science which ought to be followed uncompromisingly. He says: “If you want to teach the exact way, you need to follow exactly whatever is written in manuscripts, [isn’t] it?” And a little later he says: “Whatever is explained by lord Śiva to Pārvatī, by Pārvatī to Murukaṉ, by Murukaṉ to Akattiyar, that needs to be studied.” He argues that in college they teach an altered version of the “divine science,” which thus has “lost the sacredness that was conceived [by] the Siddhars.”[39]

Another issue that the majority of my interlocutors bring up is the type of knowledge that can be acquired in college. They describe the college as a place that only provides theoretical knowledge and that does not acknowledge the centrality of practical and experiential knowledge to Siddha medicine. They share the view that *nāṭi pārttal* for diagnosing diseases and the methods of producing drugs cannot be learnt theoretically but only practically by gaining experience from experienced persons. Prem Nath speaks in this regard of “*aṉupavam citta vaittiyam cikiccai*,” which he translates as “Siddha medicine as the treatment of the experience” (31.12.2014). The theoretical knowledge of the schoolbook is not sufficient to become a Siddha practitioner. Kapilan refers to college-trained practitioners as “bookish people” and states that “there is a danger that people who are bookish are destroying the real practical tradition of Siddha” (12.1.2015). They pose a danger to the Siddha system because they “cannot prepare Siddha medicine” (Kapilan, 12.1.2015), which, however, as mentioned above, is a defining characteristic of Siddha practice. In my interlocutors’ view, the Siddha medical texts do not contain straightforward instructions for how to practice Siddha medicine but are written in an encoded manner that is generally known as *paripāṣai* (obscure language). Rubendran says: “The books are full of secrets, and the experience-people, they find out these secrets. Each and every *śāstra*, every poem, every note has some secrets.” (6.1.2015) It is only through practice that the physician can discover the meaning of the texts and learn how to practice the medicine properly. This experiential knowledge is not, as Rubendran stresses, written down and can thus only be acquired by

39 http://www.devavidya.com/vision.html, September 29, 2016.

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learning from an experienced teacher. Apprenticeship and not studying is thus the appropriate mode of learning.

The last dominant theme in the framing of the college-trained practitioner that I want to mention revolves around the duration of the study period. Four of my interlocutors point out that the study of Siddha medicine is a long-term commitment, or, as Prem Nath puts it, a "lifetime enrolment" (31.12.2014). A Bachelor's degree in Siddha Medicine and Surgery, by contrast, is completed within only five and a half years, a timeframe within which, in my interlocutors' view, Siddha medicine cannot be mastered:

"Definitely it is not enough. It is not enough! How can you learn all those things in five and a half years? In that time we can just learn the basic things, that's it." (Rubendran, 6.1.2015)

"Let's take a *śiṣyan* [student; NR]. You know *śiṣyan*? He must learn at least twelve years under the supervision of a guru. Then only he is eligible for practice." (Surendran, 16.1.2015)[40]

4.2 The Self-Fashioning of the Hereditary Siddha Practitioner

All my interlocutors present themselves as protecting and disseminating Siddha medicine, which is congruent with their view that Siddha medicine is on the verge of disappearing and that, in order to preserve it, the medicine needs to be spread, both locally and globally. Though my interlocutors agree on the Tamil character of the medicine—according to the common narrative, Śiva gave the medical knowledge to the siddhars in the Tamil language—they also agree that Siddha medicine is not supposed to remain within the Tamil community but is destined to be a global commodity. My interlocutors' efforts to preserve Siddha medicine, or, as Kapilan says, "to rekindle the Siddha practice and Siddha way of life" (12.1.2015), is sometimes directed against biomedicine, but mainly against Siddha medicine as taught and learnt in Siddha medical colleges. This becomes evident, as I show below, in how they

40 Mr. Surendran practices Siddha medicine in his own clinic in Coimbatore and runs a business selling drugs to retailers. He has studied in a *gurukula* and has a Bachelor's degree in Siddha Medicine and Surgery.

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fashion themselves as hereditary practitioners in opposition to the college-trained practitioners and in the specific way they frame the traditional Siddha medicine. Among my interlocutors, Prem Nath challenges the college version of Siddha medicine in the most explicit way, as becomes visible in the figure of the rebel that he enacts:[41]

"Sometimes university people have a lot of trouble with me. They are thinking I am a rebel. No, I am not a rebel, but yes I am, this is my blood, this is my tradition, I cannot disobey my ancestors' comments […]." (Prem Nath, 31.12.2014)

The other interlocutors also fashion themselves as hereditary practitioners in opposition to college-educated Siddha practitioners, a position that finds expression in the criticism they articulate against them, yet they apply a less insurgent rhetoric than Prem Nath. My interlocutors employ four main themes in their fashioning of the figure of the hereditary Siddha practitioner and their framing of traditional Siddha medicine. On the basis of those four themes, they differentiate more or less explicitly the hereditary Siddha practitioner from the college-trained practitioner who serves them as a primary source of legitimacy. These four themes share a distinct religious semantics and a strong emphasis on tradition. They are: type of knowledge (man-made versus divine), access to knowledge (college versus *gurukula*), the purpose of the medicine (physical versus religious), and the motivation for the practice (money versus karma).

4.2.1 Type of Knowledge

My interlocutors differentiate between divine knowledge and man-made knowledge, portraying traditional Siddha medical knowledge as belonging to the former and the college version of Siddha medicine as well as biomedicine to the latter. As mentioned above, my interlocutors classify Siddha medicine as divine medicine, *tēvavaittiyam*, because of the medicine's provenance: Siddha medicine is not seen as an invention but as a divine discovery,

41 Prem Nath enacts the role of the rebel not only in the interview he gave me, but also in interviews on local TV channels. See, for instance, his interview on *Surya TV* (Devavidya, 2015).

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that is, as a discovery of the siddhars, the “godly people” (Anbarasi). On Prem Nath’s webpage we read:

“Palm Leaf Manuscripts says [*sic*] that the Siddha System of medicine was first taught by Lord Shiva to his wife Goddess Parvathy. Goddess Parvathy in turn passed on all these knowledge to her son Lord Muruga. Lord Muruga then taught Siddha Medicine to his favorite disciple Sage Agasthya. It was from Agasthya and his disciples, the 18 Siddhars, the great wisdom of Siddha spread to what it is today.”[42]

The divine nature of Siddha medical knowledge is expressed in different ways, the most dominant being its characterization as absolute knowledge. Avalok, for example, speaks of Siddha medicine as a complete body of knowledge that the siddhars have obtained and transmitted, and Anbarasi says in a similar vein:

“Everything is there. You cannot go anywhere from here. Everything is written. Everything is finished. Everything is over. There is no need to find new things. Everything is written. You just have to take and do and give. It will be effective.” (Anbarasi, 6.1.2015)

Prem Nath also speaks of the completeness of Siddha medicine, his point being that it is flawless and unerring knowledge. In this connection, he complains that, if a treatment is unsuccessful, college-trained practitioners blame the medicine for the failure. However, as he also says: “There is no mistake happening in the science, only in the scientist.” (31.12.2014)

The absolute character of the medicine is also expressed on the basis of its timelessness. As I have already mentioned, Siddha medicine is contrasted with biomedicine on the basis that Siddha medicine will never correct itself. Surendran states:

“The medicines present today will disappear in five years. But our medicines, no one will ever change them. Even one million years after. It was their [the Siddhars’] intuition, by meditation [‘they obtained it’].” (Surendran, 16.1.2015)

42 http://www.devavidya.com/siddhavaidyam.html, June 29, 2016.

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Furthermore, as I mentioned before, Prem Nath argues that humans are not supposed to change anything in the Siddha knowledge, since any alteration of divine knowledge is a corruption of the absolute knowledge, an argument he uses to challenge the college version of Siddha medicine: "If I invent something, it is a fake statement." (31.12.2014) He says that he has "no right" to customize the knowledge because he is not the creator of the knowledge, but only a medium who transfers this knowledge on to others: "I am an agent. The masters are above me, beyond my control."[43] Prem Nath thus demands proper respect for it: "[…] when a god gives you a chance to know these things, don't neglect, don't challenge the god; you have to obey the orders of divine source." Anbarasi and Surendran too stress that it is crucial that they exactly follow "whatever is written in the literature" (Anbarasi, 6.1.2015) in order to produce good medicine.

4.2.2 Access to Knowledge

My interlocutors claim to have access to the complete Siddha knowledge because they have studied in a *gurukula* with hereditary Siddha physicians, who are believed to hold the real knowledge, unlike the colleges. The "key books," as Prem Nath notes, are in the hands of hereditary practitioners, and the knowledge they contain is only transmitted through hereditary lineages: "blood is thicker than water," he says proverbially to indicate that Siddha knowledge is not shared with outsiders but remains within the family (31.12.2014). The importance of the sense of belonging to a lineage of hereditary Siddha practitioners is also reflected in Prem Nath's self-presentation on his webpage:

"Prem Nath hails from a traditional Siddha family dating back to pre-british [*sic*] era in India. His family migrated to Kerala from Pandi Kingdom of Tamil Nadu on the

43 Prem Nath is reflexive about innovative elements in his own practices, such as running a website, providing consultancy through skype, appearing on TV, or offering an online Siddha training program. He applies the analogy of "old wine in a new bottle" to point out that the form of knowledge transmission can be altered if this is beneficial for the quest to preserve divine knowledge, though the knowledge itself ought not to be changed.

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request of the king Cheraman Perumal to provide Varmam training[44] to his military as well as to serve as Siddha physicians in the court. […] The most revered vaidyam of his lineage is the Velitheriyil Kesavan Vaidyan about whom even poets have sung."[45]

His webpage also states that his family possesses texts composed by the siddhars: "He hails from a traditionally reputed family of Siddha Physicians. They have [a] huge collection of old secret manuscripts about Siddha Science."[46] Avalok too claims to belong to a hereditary Siddha family in the fifth generation, and he states that he learnt Siddha medicine with his grandfather and that the Siddha manuscripts which he showed me belong to his family. Surendran also states that he stayed with different hereditary practitioners in order to learn the art of medical production, which is kept secret from outsiders. And Rubendran points out decisively that he belongs to a lineage of hereditary practitioners. He opens his account by saying that he belongs to the fifteenth generation of practitioners in his family. The element of lineage is also strongly present on his webpage. The "About Us" section on the webpage starts with the following sentences:

"The founder of Agasthiyar Siddha Ayurveda Hospital was the Great Legend Late Dr. Sri Brahmananda Swamigal. He was born […] as the 4th son of Sivadha Achary, a well-known traditional siddha physician and Ammaluammal. He got interested in medicine at the age of 8 yrs. So he started his Gurukulam period under his respectful master Sri Velayuthampillai from Thiruvettar in Kanyakumari District."[47]

The webpage also informs the reader that Dr. Sri Brahmananda Swamigal, who is Rubendran's father, also "gathered much knowledge of traditional Siddha medicine from his father" and that he had two other gurus. Rubendran stresses that he has studied Siddha medicine since childhood under the guidance of his father and thus learnt how to produce drugs, which is impossible in the college setting:

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44 "Varma training" refers to *varmakkalai*, the art of the vital spots, a technique which constitutes a sub-branch of Siddha medicine; cp. Sieler 2015, 2012.

45 http://www.devavidya.com/management.html, September 29, 2016.

46 http://www.devavidya.com/about.html, September 29, 2016.

47 http://agasthiyarsiddhaayurveda.com/aboutus.html, June 2, 2017.

https://doi.org/10.14361/9783839445822-005 https://www.inlibra.com/de/agb - Open Access -

"Nobody in any university or any college can teach these medicine preparation or purification, because they don't know. They don't know. The teachers, they don't know how to prepare. That is what I told you. Many of the poems, they have a secret. Those secrets are never taught in the colleges, never taught in the universities, that is, only hereditary people, they only know." (Rubendran, 6.1.2015)

This quote shows that from my interlocutor's point of view access to knowledge depends not only on physical access to the manuscripts, but also on access to their meaning, which requires someone with the expertise to decode the encrypted information contained in the Siddha poems.

4.2.3 Purpose of the Medicine

A further recurring theme is the purpose of the medicine. Four of my interlocutors express the view that Siddha medicine's ultimate objective is not to cure a physical sickness, but to serve as a means to unify with god, that is, to attain liberation, a view which is not "their own," but which is present in the classical Siddha literature.[48] They share the view that the siddhars have passed on a medical system which guarantees longevity.[49] Kapilan even speaks of "deathlessness" (12.1.2015). Longevity in turn allows for more time to complete the process of spiritual perfection, which will ultimately lead, as Devanesan says, to "a connection between the soul and the divine" (5.2.2015), by which he means liberation (*jīvaṉmukti*). The theme of liberation is most distinctly discussed by Anbarasi, who makes the strong point that wellbeing is a precondition for liberation. Siddha medicine, according to Anbarasi, is a means to purify the body and the mind, which is needed for doing good things in society and is, in turn, a step towards one's merging with god. In her view what might appear to be a preventive and rejuvenating medicine serves a religious purpose. She says:

"So those who are strong in physical, they will reach god, they will do service to the people with their healthy body, so they will reach god. This is the main aim of our Siddhars." (Anbarasi, 6.1.2015)

48 Cp., for instance, Zvelebil 1973: 29.

49 They are referring to *kāyakaḻpa*, a major subfield of Siddha medicine which teaches techniques for the prolongation of life.

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And elsewhere she states:

"If our body is healthy only, we can do, with the help of this body only we can do service to the society […]. We will become part of god in future. That is the main thing of the Siddhars." (Anbarasi, 6.1.2015)

4.2.4 Motivation for the Practice

The fourth dominant theme in the fashioning of traditional Siddha medicine that I wish to highlight revolves around the question of the motivation for carrying out this medical practice. All my interlocutors express the view that a main characteristic of the hereditary Siddha practitioner is that he or she is not driven by entrepreneurial motives but rather practices Siddha medicine out of a sense of duty. They all present themselves as working for the preservation of Siddha medicine, which they describe as their duty towards humanity and their tradition. Devanesan, for example, speaks of it being his duty to protect Siddha medicine from disappearing, and Avalok states that he makes great efforts to share his knowledge with other traditional physicians in order to preserve it. Prem Nath too describes his Siddha medical activities as a duty, an idea he connects with the supposedly divine nature of the medicine. He states that Siddha medicine was "developed for human beings" and that he therefore wants to turn the secretly kept knowledge into "a public property" and make it accessible to the people (31.12.2014). He states that this is a duty which was given to him by god:

"Without the grace of god and master, we cannot do it [practice the medicine]; if god opens a gateway to the system, we have to enter it, realize it, not for you, but for your people." (Prem Nath, 31.12.2014)

Anbarasi equates duty with karma: "Definitely, it is a duty, it is karma" (6.1.2015), and she goes on to say that she does her Siddha medical work out of a sense of karma, without any financial motivation. Four of my interlocutors express the view that executing a (divine) duty should not be a means of making money. Prem Nath, for example, states that there "cannot be a business motivation; money is wrong motivation," and elsewhere he says that "healing is not […] for money. It has a divine, a divine source, a divine vision" ((31.12.2014). And finally, my interlocutors contrast their non-

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entrepreneurial motivations with the motivations of the college-trained Siddha practitioners, which they unanimously describe as being financial in nature. Devanesan says, for example: "The modern way is, it is a commercial way, you know, [it is] business" (5.2.2015). In my interlocutors' view, the quintessential materialization of the commercialization of Siddha medicine is the pharmaceutical companies that are competing for money. Anbarasi states:

"Another big company is INCOPS, a government company in Chennai. But the INCOPS medicine, they are making them for commercial purpose. They are supplying all primary health centers all over Tamil Nadu. […] But they are going commercial. Myself, we are not commercial; our medicine should act well […], so we are concentrating on the quality of the medicine." (Anbarasi, 6.1.2015)

While my interlocutors describe the college-trained practitioner and pharmaceutical companies as prioritizing economic profit over quality, they fashion themselves as giving the utmost importance to quality and as having no interest in financial profit.

5 SEMANTIC POSITIONING IN A STRATEGIC ACTION FIELD

5.1 Positioned Semantics

The finding of the similarities and overlaps in my interlocutors' accounts could be interpreted in different ways, such as mere coincidence, the result of the particular interview situation, or the reproduction of a dominant discursive strand. The finding could also be viewed as an expression of the shared structural constraints within which the accounts are constructed, which indeed is the interpretation I suggest applying. I will argue for this interpretation on the basis of Bourdieu's proposition that

"[…] social space is so constructed that agents who occupy similar or neighboring positions are placed in similar conditions and subjected to similar conditionings, and therefore have every chance of having similar dispositions and interests, and thus of producing practices that are themselves similar." (Bourdieu 1989: 17)

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Accordingly, I adopt the position that my interlocutors internalize their structural conditions and enact them in their practices, thus producing similar semantic patterns which become apparent in their accounts. This Bourdieuesque stance that the individual is socially constituted does not imply that the individual does not "possess the necessary properties" to structure the field him- or herself (Bourdieu/Wacquant 1992: 107). According to Bourdieu, the individual is both socially structured by the field and also actively structures the field.[50] I go with this proposition in so far as I do not consider my interlocutors as mere "epiphenomena of structures" (Honneth et al. 1986: 41), nor regard their semantic construction of the figure of the hereditary Siddha practitioner as an act of tacit reproduction of what the objective structures allow to be articulated. Rather, I suggest that my interlocutors recognize and reproduce symbols of authority in their self-fashioning while also consciously reconfiguring them, at least partially, that is, within the structuring framework of their social position. I understand their self-fashioning in this sense as "regulated improvisations" (Bourdieu 1990: 59), a term which interweaves the embodiment of objective structures with human agency.

What are these symbols of authority, and how are they reconfigured in my interlocutors' accounts? The most dominant symbol of authority is science and biomedicine. As I have already mentioned, the professionalization of Siddha medicine meant the adaptation of the Siddha medical tradition to the biomedical paradigm and the introduction of the secular, scientific rationale as the yardstick of its validity. Clearly, my interlocutors recognize the biomedical paradigm. The majority of them frame Siddha medicine as a science; they speak of the efficacy of their drugs, provide catalogues with treatments and medication to their patients, and use a biomedical vocabulary to describe diseases. However, they also interweave a religious semantics with the scientific semantics and in doing so reconfigure the notion of science. In their accounts Siddha medicine is not just a science, it is a divine science, a science, moreover, with absolute validity and completeness, a science that has not been invented by mortal scientists but was discovered by the siddhars.

And what are the structural conditions to which the fashioning of the figure of the hereditary Siddha practitioner is subjected? As has hopefully

50 Kaldewey (2015: 104) uses the term "co-construction" to describe the relationship between the subject's habitus and the social field.

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become clear in the preceding sections, I argue that the semantic figure of the hereditary Siddha practitioner emerged as a reaction to the professionalization of Siddha medicine. The specific fashioning of this figure can be read as an expression of their perceived struggle to preserve and disseminate their knowledge and practice with the authority of which it has been deprived in the process of the professionalization of Siddha medicine. As I stated above, the professionalization of Siddha medicine induced, at least normatively, a standardization of the medical system. This led to the creation of a more homogenized version of Siddha medicine and to the delegitimization of certain forms of knowledge and practice. I argue that it is my interlocutors' experience of the marginalization of their knowledge which leads them to formulate narratives that confront the dominant version of Siddha medicine. Thus, their accounts can be read as alternative narratives that on the one hand recognize the scientific paradigm, yet on the other hand interweave a religious semantics with the scientific semantics, producing counterhegemonic accounts as a result.

So why, one might ask, do religious semantics and tradition figure so prominently in these counterhegemonic accounts? Generally speaking, interpretative social scientists are wary of asking for explanations because they carry an air of positivism and determinism at worst and provide a reductionist analysis at best (Charmaz 2006: 126). Nevertheless, I will point to one possible explanation for the distinct delineation of the hereditary Siddha practitioner in my interlocutors' accounts. I suggest that the rhetoric of religion and tradition is particularly effective as a symbolic resource because the college version of Siddha medicine prioritizes a scientific over a religious logic and uses a secular, scientific rationale as the yardstick for its validity, or to put it more generally, because the professionalization of Siddha medicine entailed a secularization of the Siddha system. The government's recognition of Siddha medicine as an Indian medicine and its integration into the AYUSH ministry alongside other medical systems—and not, for example, into the Ministry of Culture—happened alongside its "scientification." By emphasizing religious elements in the depiction of the "real" Siddha medicine, my interlocutors accentuate exactly those elements that are absent from their constitutive outside. Furthermore, the college version of Siddha medicine is not guarded by a religious authority but by a secularized medical profession. The representatives of the college version of Siddha medicine do not appear as religious experts, but rather as medical experts who are close to the

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biomedical profession and not to any religious group or community. Hence, the representatives of the college version of Siddha medicine are not interested in participating in a religious discourse and therefore do not pose a challenge to my interlocutors' religious strategy: the medical authority will not question my interlocutors' religious semantics or confront it with an alternative religious interpretation, which makes it a powerful strategy. Finally, reference to religion, whether by emphasizing its divine provenance, stressing the sacredness of the knowledge or introducing concepts such as *jīvaṉmukti*, grants my interlocutors a degree of stability and independence which they would not acquire if they were trying to authorize their knowledge by obtaining the backing of other medical entities such as the WHO or medical research institutes. Reference to religion is unproblematic and is favored because religion appears as an independent entity. This is particularly true of the Hindu religion, which is the source of my interlocutors' claims to legitimacy: there is no higher or centralized religious authority in the Hindu religion which could challenge my interlocutors' narratives, and the religious figures they draw on are the gurus, the siddhars and Śiva, who, however, are both absent and invisible.[51]

5.2 Competition for Power

Shmuel Eisenstadt states concisely that processes of institutionalization entail "the creation and definition of norms to regulate the major units of social behavior and organization," as well as the "criteria according to which the flow of resources is regulated between such units, and sanctions to ensure that such norms are upheld" (1964: 235f). It is hardly surprising that the creation, definition, and sanctioning of norms involves struggles over power because these practices set standards which marginalize and exclude certain actors. The present section deals with these power struggles.

What is meant by power and power struggles? A social field in the Bourdieusque relational view is a "*field of struggle*" (Bourdieu/Wacquant 1992: 101, emphasis in the original) in which the actors strive to maintain or improve their relative positions. The relationship between different positions is structured on the basis of the distribution of the power that is valid within a particular social field (ibid: 97). Possessing power encompasses the authority

51 For a discussion of the role of the guru in Hinduism, cp. Mlecko 1982.

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to grant or refuse access to resources and to decide about the inclusion of people in and their exclusion from "the game". Bourdieu speaks here of "symbolic power" (1989: 22), that is, the "power of 'world-making'" (ibid: 22). It is this struggle for symbolic power that is at stake in the accounts of my interlocutors, the struggle over the power to formulate criteria of legitimacy, competence, and validity. Bourdieu equates power metaphorically with capital, a concept that he extends from material to intangible resources. He argues that the unequal distribution of capital structures the arrangement in the field and that the possession of power coincides with the possession of capital (Bourdieu/Wacquant 1992: 97). Bourdieu identifies four key types of capital, the four "fundamental powers" (1989: 17) of economic, cultural, social, and symbolic capital, which are relationally linked to the concepts of field and habitus in his theoretical framework. Capital is field-specific, meaning that the different types of capital become effective in different fields. "Fields designate arenas," as Swartz paraphrases Bourdieu's stance, "where specific forms of capital are produced, invested, exchanged, and accumulated" (1996: 78). I want to argue that it is the production, investment, exchange, and accumulation of cultural capital that is at stake in the present case of the Siddha medical field.[52] In his numerous writings, Bourdieu uses the concept of cultural capital in different ways, giving it a polysemic character. Yet, broadly speaking, it can be described as a concept that pinpoints cultural resources as the basis for social inclusion and a means to improve one's social position. Swartz (1996: 75–76) states: "His point is to suggest that culture in the broadest sense of the term) can become a power resource." According to Bourdieu, cultural capital appears in three different types. It exists in an incorporated form, that is, in the form of embodied knowledge, of cultivated dispositions, or the habitus which a person has acquired (Bourdieu 1992: 55). Secondly, it exists in an objectified form, that is, in the form of material goods which make cultural capital materially transmittable (Bourdieu 1992: 59). Finally, it exists in an institutionalized form, that is, in

52 In the eyes of Bourdieu, application of the term "cultural capital" might appear inappropriate here because he uses the term to denote signals which stem from the dominant culture. However, I am using the term to denote not that their cultural capital reflects the "*répertoire* of high status cultural signals" (Lamont and Lareau 1988:161, emphasis in the original), but that they have competence in the repertoire of "marginal high status signals" (ibid: 157).

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educational credentials which sanction the incorporated capital (Bourdieu 1992: 61). Thus, cultural capital, unlike economic capital, does not follow an economic rationale and does not generate an economic profit in the first instance, but a symbolic value. The symbolic value is typically expressed in official nominations such as titles, recognized qualifications, and certifications which generate prestige, honor, or recognition (Bourdieu 1989: 21).

If we analyze the accounts of my interlocutors under these conditions, we see that Siddha medicine appears as cultural capital in their accounts, yet that they create an alternative version of cultural capital to the dominant form. In my interlocutors' discursive reality, the embodiment of knowledge generates prestige, honor, or recognition, yet it is not the accumulation of college knowledge but the accumulation of hereditary, traditional Siddha knowledge. The latter knowledge finds expression in an objectified form, in material objects which are not college books but old manuscripts. And the hereditary Siddha medicine appears as institutionalized cultural capital, not in the form of college diplomas attesting to college training, but in the form of membership of a *gurukula* which sanctions their claim to possess the "real" Siddha knowledge. The elements which act in my interlocutors' accounts as cultural capital correspond to those elements which are excluded from the college version of Siddha medicine. My interlocutors' alternative cultural capital is knowledge which is not tied to a modern educational institution, but to traditionally authoritative persons and lineages. My interlocutors refuse to acknowledge the capital of the college institution and construct instead the hereditary knowledge that is not certified by a BSMS as an alternative capital. This alternative capital serves them as a resource for the power with which they strive to improve their position in the field.

5.3 Strategic Semantics

I suggest conceptualizing the semantic construction of the figure of the hereditary Siddha practitioner as the expression of a strategy in a social field. Bourdieu's term "strategy" is far from being a voluntaristic and subjective pursuit of unrestricted freedom in a deliberate improvisation. Swartz (1996: 76) states concisely: "Bourdieu's actors pursue strategies but not as conscious maximizers of limited means to achieve desired ends." A strategy is

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tied to the game in which it is played out and connotes "a feel for the game" (Lamaison/Bourdieu 1986: 111).[53]

Examining my interlocutors' accounts, I suggest that they pursue a strategy of heresy and that they speak from the semantic position of the challenger. Moreover, I suggest that they position themselves in opposition to the college-educated practitioner, who figures as the incumbent in the social field. The analytical distinction between the challenger and the incumbent has been introduced by Fligstein and McAdam (2012) in their analysis of the workings of strategic action fields, which is their own conceptual development of Bourdieu's concept of field.[54] They argue that strategic action fields are sites of constant rearrangements: "In short, we expect strategic action fields to always be in some sort of flux, as the process of contention is ongoing and the threats to an order always present to some degree." (Fligstein/McAdam 2012: 13) Responsible for this flux are the two figures of the challenger and incumbent, which (together with the governance units) compose a strategic action field.[55] Incumbents are the actors "who wield disproportionate influence within a field and whose interests and views tend to be heavily reflected in the dominant organization of the strategic action field" (ibid: 13). It is the incumbents' interests which structure the field. Challengers, on the other hand, occupy a less influential position within the field. According to Fligstein and McAdam, challengers "recognize the nature of the

53 With this stance, Bourdieu distinguishes his own concepts from rational action theory and stresses that actors' choices are tacit and dispositional and are determined by their socialization and the opportunities and constraints provided by the field in which they act.

54 Fligstein and McAdam define a strategic action field as a "constructed mesolevel social order in which actors (who can be individual or collective) are attuned to and interact with one another on the basis of shared (which is not to say consensual) understandings about the purposes of the field, relationships to others in the field (including who has power and why), and the rules governing legitimate action in the field" (2012: 9).

55 The analytical distinction between incumbent and challenger can be traced back to Bourdieu's differentiation between conservation strategy and strategy of heresy (1993: 73). According to Bourdieu, conservation strategies are followed by the orthodox, those who aim at the consolidation of the social order, whereas strategies of heresy are pursued by the heterodox, those whose aim is its subversion.

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field and the dominant logic of incumbent actors," but formulate an alternative version of the social field and their position within it (ibid: 13).

I argue that the circumstances generated by the professionalization of Siddha medicine lead my interlocutors to articulate an alternative version of the social order to secure for themselves a position in the social field. In this alternative version, they disparage the knowledge of the college-trained practitioner as corrupted, whereas they assess their own knowledge as being of divine provenance and hence flawless. They claim that they learnt the "real" Siddha medicine from practitioners who stand in a lineage of hereditary Siddha physicians who trace their origin ultimately back to the siddhars. Clearly, my interlocutors' semantic strategy does not aim at consolidating the social order. On the contrary, they try to reframe the social order in a way that is profitable to them. In this sense, I argue that their self-fashioning as hereditary Siddha practitioners and their devaluation of the latter's knowledge is to be interpreted as attempts to attain a different status in the social field. Their claim to belong to a lineage of hereditary Siddha physicians and the distinct stylization of traditional Siddha knowledge serve them as weapons with which to counter the dominant position in the field and the dominant narrative. My interlocutors need a "weapon" in order to maintain and bring into the present their understanding of Siddha medicine, in which lineage is an integral part. Only if the element of lineage is accepted as a relevant feature of the medical tradition can my interlocutors survive and thrive.

6 CONCLUSION

From my interlocutors' point of view, the recognition of the Siddha medical system by the Indian government and its integration into the public health sector does not favor the medicine's preservation, nor does it have an empowering effect on Siddha practitioners. On the contrary, they argue that it has corrupted the divine medicine. Furthermore, they argue that recent developments have undermined their authority and restricted them in their agency, subjecting them to a multitude of regulations. This is a common assessment made by my interlocutors, who fashion themselves as hereditary Siddha practitioners. However, from an analytical perspective it can be argued that it was precisely the formal professionalization of Siddha medicine that created the conditions under which the semantic figure of the hereditary

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Siddha practitioner could emerge. The conditions created by the professionalization of Siddha medicine allow Siddha practitioners like my interlocutors to position themselves in relation to college-trained practitioners and to fashion their self-image in opposition to them. The figure of the hereditary practitioner thus appears as a counterpoint to the college-trained practitioner. Though the hereditary practitioner opposes the college-educated practitioner, they stand in a symbiotic relationship. It is only in this opposition that the religious semantics becomes effective and the figure of the hereditary Siddha practitioner becomes meaningful. Though the heterodox strategy of the challenger and the orthodox strategy of the incumbent are two distinct strategies, they need to be seen as mutually constitutive: "Orthodoxies," as Swartz puts it (1996: 80), "call into existence their heterodox reversals by the logic of distinction that operates in cultural fields." Obviously, this argument does not aim to make the dread expressed by my interlocutors less real or less valid. However, it does deconstruct their accounts as discursive strategies and reminds us of their historical contingency. The argument stresses that the semantic construction of the hereditary Siddha practitioner aims at reconstituting the epistemic hierarchies. Accordingly, I propose that the hereditary Siddha practitioner be conceptualized as following a strategy of heresy or the strategy of a challenger, both of which aim to improve the challenger's social position in the field. Moreover, I suggest their narratives, which give space to religion and emphasize tradition, should be read as a mode of cultural production through which they attempt to attain a different status in the social field. The adoption of a religious semantics and the emphasis on tradition become effective in this strategy because my interlocutors position themselves in opposition to an "other" who lacks those very qualities.

BIBLIOGRAPHY

Arnold, David (2000): The New Cambridge History of India: Science, Technology and Medicine in Colonial India, Cambridge: Cambridge University Press.

Bala, Poonam (2007): Medicine and Medical Policies in India: Social and Historical Perspectives, Lanham: Lexington Books.

Bernard, Russell H (2011): Research Methods in Anthropology: Qualitative and Quantitative Approaches. 5th edn., Lanham: AltaMira Press.

https://doi.org/10.14361/9783839445822-005 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

Bourdieu, Pierre (1989): "Social Space and Symbolic Power", in: Sociological Theory (7/1), pp. 14–25. doi:10.2307/202060.

Bourdieu, Pierre (1990): The Logic of Practice, Stanford: Stanford University Press.

Bourdieu, Pierre (1992): Die verborgenen Mechanismen der Macht (=Schriften zu Politik & Kultur, Volume 1), Hamburg: VSA-Verlag.

Bourdieu, Pierre (1993): Sozialer Sinn: Kritik der theoretischen Vernunft, Frankfurt am Main: Suhrkamp.

Bourdieu, Pierre/Wacquant, Loïc J.D. (1992): An Invitation to Reflexive Sociology, 1st edn., Chicago: The University of Chicago Press.

Brass, Paul (1972): "The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India", in: Susanne Hoeber Rudolph/Lloyd I. Rudolph (eds.), Education and Politics in India: Studies in Organization, Society and Policy, Cambridge MA: Harvard University Press, pp. 342–371.

Broman, Thomas (1995): "Rethinking Professionalization: Theory, Practice, and Professional Ideology in Eighteenth-Century German Medicine", in: The Journal of Modern History (67/4), pp. 835–872.

Broom, Alex/Assa Doron/Philip Tovey (2009): "The Inequalities of Medical Pluralism: Hierarchies of Health, the Politics of Tradition and the Economies of Care in Indian Oncology", in: Social Science & Medicine (69/5), pp. 698–706.

Charmaz, Kathy (2006): Constructing Grounded Theory: A Practical Guide through Qualitative Analysis, London: Sage.

Daniel, Valentine (1984): "The Pulse as an Icon in Siddha Medicine", in: Contribution to Asian Studies (18), pp.15–26.

Dumit, Joseph (2010): "A Digital Image of the Category of the Person", in: Byron J. Good/Michael M.J. Fischer/Sarah S. Willen/Mary-Jo DelVecchio Good (eds.), A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities, Oxford: Wiley-Blackwell, pp. 367–376.

Eisenstadt, Shmuel N. (1964): "Institutionalization and Change", in: American Sociological Review (29/2), pp. 235–247. doi:10.2307/2092126.

Engler, Steven (2003). "'Science' vs. 'Religion' in Classical Ayurveda", in: Numen (50/4), pp. 416–463.

Fischer-Tiné, Harald (2013): Pidgin-Knowledge: Wissen und Kolonialismus, Zurich: Diaphanes.

https://doi.org/10.14361/9783839445822-005 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

Fligstein, Neil/Doug McAdam (2012): A Theory of Fields, New York: Oxford University Press.

Gamson, William A. (1985): “Goffman’s Legacy to Political Sociology”, in: Theory and Society (14/5), pp. 605–622.

Glaser, Barney G. (1978): Theoretical Sensitivity: Advances in the Methodology of Grounded Theory, Mill Valley: Sociology Press.

Goffman, Erving (1974): Frame Analysis: An Essay on the Organization of Experience, Cambridge: Harvard University Press.

Habib, S. Irfan/Dhruv Raina (2005): “Reinventing Traditional Medicine: Method, Institutional Change, and the Manufacture of Drugs and Medication in Late Colonial India”, in: Joseph Alter (ed.), Asian Medicine and Globalization (Encounters with Asia), Philadelphia: University of Pennsylvania Press, pp. 67–77.

Hall, Stuart (2003): “Introduction: Who Needs ‘Identity’?”, in: Stuart Hall/Paul Du Gay (eds.), Questions of Cultural Identity, London: Sage, pp. 1–17.

Hardiman, David (2009): “Indian Medical Indigeneity: From Nationalist Assertion to the Global Market”, in: *Social History* (34/3), pp. 263–283.

Hausman, Gary (1996): Siddhars, Alchemy and the Abyss of Tradition: ‘Traditional’ Tamil Medical Knowledge in ‘Modern’ Practice. PhD dissertation, University of Michigan.

Honneth, Axel/Kocyba, Hermann/Schwibs, Bernd (1986): “The Struggle for Symbolic Order: An Interview with Pierre Bourdieu”, in: Theory, Culture & Society (3/3), pp. 35–51. doi:10.1177/026327686003003005.

Jansen, Eva (2016): Naturopathy in South India: Clinics between Professionalization and Empowerment. (=Sir Henry Wellcome Asian Series), Leiden: Brill.

Kaldewey, David (2015): “Tacit Knowledge in a Differentiated Society”, in: Frank Adloff (ed.), Revealing Tacit Knowledge: Embodiment and Explication, Bielefeld: transcript, pp. 87–112.

Krishnamurthy, K. H./Mouli, Chandra (1984): “Siddha System of Medicine: A Historical Appraisal”, in: Indian Journal of History of Science (19/1), pp. 43–53.

Kuckartz, Udo (1991): “Ideal Types or Empirical Types: The Case of Max Weber’s Empirical Research”, in: Bulletin of Sociological Methodology/Bulletin de Méthodologie Sociologique (32/1), pp. 44–53.

https://doi.org/10.14361/9783839445822-005 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

Laclau, Ernesto (1995): “Subject of Politics, Politics of the Subject”, in: Differences: A Journal of Feminist Cultural Studies (7/1), pp. 146–164.

Lamaison, Pierre/Bourdieu, Pierre (1986): “From Rules to Strategies: An Interview with Pierre Bourdieu”, in: Cultural Anthropology (1/1), pp. 110–120.

Lamont, Michèle/Lareau, Annette (1988): “Cultural Capital: Allusions, Gaps and Glissandos in Recent Theoretical Developments”, in: Sociological Theory (6/2), pp. 153–168. doi:10.2307/202113.

Lamont, Michèle/Lareau, Annette/Molnár, Virág (2002): “The Study of Boundaries in the Social Sciences”, in: Annual Review of Sociology (28/1), pp. 167–195. doi:10.1146/annurev.soc.28.110601.141107.

Langford, Jean M (2002): Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance, Durham: Duke University Press.

Last, Murray (1996): “The Professionalization of Indigenous Healers”, in: Carolyn Fishel Sargent and Thomas M. Johnson (eds.), Handbook of Medical Anthropology: Contemporary Theory and Method, revised edn., Westport: Greenwood Press, pp. 374–395.

Leslie, Charles (ed.) (1976): Asian Medical Systems: A Comparative Study, Berkeley: University of California Press.

Mlecko, Joel D (1982): “The Guru in Hindu Tradition”, in: Numen (29/1), pp. 33–61. doi:10.1163/156852782X00132.

Naraindas, Harish/Quack, Johannes/Sax, William S. (eds.) (2014). Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries, 1st edn., New York: Berghahn Books.

Payyappallimana, Unnikrishnan/Hariramamurthi, Govindaswamy (2012): “Local Health Practitioners in India: Resilience, Revitalisation and Reintegration”, in: V. Sujatha/Leena Abraham (eds.), Medical Pluralism in Contemporary India, New Delhi: Orient Blackswan, pp. 279–304.

Priya, Ritu (2012): “AYUSH and Public Health: Democratic Pluralism and the Quality of Health Services”, in: V. Sujatha/Leena Abraham (eds.), Medical Pluralism in Contemporary India, New Delhi: Orient Blackswan, pp. 103–129.

Ranganathan, Aruna (2013): “Professionalization and Market Closure: The Case of Plumbing in India”, in: ILR Review (66/4), pp. 902–932.

Schlehe, Judith (2003): “Qualitative ethnographische Interviewformen”, in: Bettina Beer (ed.), Methoden und Techniken der Feldforschung, Berlin: Reimer, pp. 71–93.

https://doi.org/10.14361/9783839445822-005 https://www.inlibra.com/de/agb - Open Access - cc BY-NC-ND

Sébastia, Brigitte (2012a): "Competing for Medical Space: Traditional Practitioners in the Transmission and Promotion of Siddha Medicine", in: V. Sujatha/Leena Abraham (eds.), Medical Pluralism in Contemporary India, New Delhi: Orient Blackswan, pp. 165–185.

Sébastia, Brigitte (2012b): Governmental Institutions vs. Associations: The Multifaceted Expression of Siddha Medicine in Tamil Nadu. Article qui sera publié dans un ouvrage collectif, pp. 1–17. <halshs-00408677>

Sieler, Roman (2014): "Patient Agency Revisited: 'Healing the Hidden' in South India", in: Medical Anthropology Quarterly (28/3), pp. 323–341. doi: 10.1111/maq.12067.

Sieler, Roman (2015): Lethal Spots, Vital Secrets: Medicine and Martial Arts in South India, New York: Oxford University Press.

Sujatha, V. (2011). "Innovation Within and Between Traditions: Dilemma of Traditional Medicine in Contemporary India", in: Science, Technology & Society (16/2), pp.191–213. doi:10.1177/097172181001600204.

Sujatha, V./Abraham, Leena (2009): "Medicine, State and Society", in: Economic and Political Weekly (44/16), pp. 35–43.

Swartz, David (1996): "Bridging the Study of Culture and Religion: Pierre Bourdieu's Political Economy of Symbolic Power", in: Sociology of Religion (57/1), pp. 71–85.

Venkatraman, Ramaswamy (1990): A History of the Tamil Siddha Cult, Madurai: Ennes Publications.

Weiss, Richard (2005): "The Autonomy of Tradition: Creating Space for Indian Medicine", in: Steven Engler/Gregory Price Grieve (eds.), Historicizing 'Tradition' in the Study of Religion (Religion and Society), Berlin: Walter de Gruyter, pp. 175–194.

Weiss, Richard (2008): "Divorcing Ayurveda: Siddha Medicine and the Quest for Uniqueness", in: Dagmar Wujastyk/Frederick Smith (eds.), Modern and Global Ayurveda: Pluralism and Paradigms, New York: State University of New York Press, pp. 77–99.

Weiss, Richard (2009): Recipes for Immortality: Medicine, Religion, and Community in South India, Oxford: Oxford University Press.

White, David Gordon (1996): The Alchemical Body: Siddha Traditions in Medieval India, Chicago: The University of Chicago Press.

Wujastyk, Dagmar/Smith, Frederick M. (eds.) (2008): Modern and Global Ayurveda: Pluralism and Paradigms, Albany: State University of New York Press.

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Zvelebil, Kamil (1973): The Poets of the Powers, London: Rider.
Zvelebil, Kamil (1974): Tamil Literature, Wiesbaden : Otto Harrassowitz.
Zvelebil, Kamil (1996): Siddha Quest for Immortality, Oxford: Red Wheel Weiser.

LINKS

http://agasthiyarsiddhaayurveda.com/aboutus.html, June 2, 2017.
http://www.ccimindia.org/siddha-syllabus.php, July 10, 2016.
http://www.devavidya.com/siddhavaidyam.html, June 29, 2016.
http://www.devavidya.com/siddhatraining.html, September 29, 2016.
http://www.devavidya.com/management.html, September 29, 2016.
http://www.devavidya.com/about.html, September 29, 2016.
http://www.devavidya.com/vision.html, September 29, 2016.
http://www.siddhavaidyam.com/Origin_of_SiddhaMedicine.html, August 18, 2017.
http://www.siddhavaidyam.com/Principles_of_SiddhaMedicine.html, August 18, 2017.
http://www.siddhavaidyam.com/siddhavaidyam.html, August 18, 2017.

https://doi.org/10.14361/9783839445822-005 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND