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Toward a Global History of Buddhism and Medicine

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Abstract

The close relationship between Buddhism and medicine that has become so visible thanks to the contemporary 'mindfulness revolution' is not necessarily unique to the twenty-first century. The ubiquitous contemporary emphasis on the health benefits of Buddhist and Buddhist-inspired practice is in many ways the latest chapter in a symbiotic relationship between Buddhism and medicine that is both centuries-long and of global scope. This article represents the first steps toward writing a book that explores the global history of Buddhism and medicine 'from Sarnath to Silicone Valley'. It identifies patterns in the transmission and reception of texts and ideas, networks of circulation, and intersections with local and regional histories that shaped the history of Buddhist ideas and practices concerning physical health and healing

Keywords
Buddhism, medicine, healing, cross-cultural exchange, circulation, networks

Introduction

Thanks to the meteoric rise of meditation in the public eye recently, the links between Buddhism and health have become a practically ubiquitous topic in the English-language academic, scientific, and popular media.[1] A Google search for the keyword combinations 'Buddhism' or 'Buddhist' plus 'health' conducted

1. This article is a much-expanded version of the first part of the paper given at the 2014 UKABS conference. Drafts of it were presented in 2015 at the Georgetown Critical Silk Road Studies seminar, the Philadelphia Area Buddhist Studies Work Group, the Harvard Buddhist Studies Forum, and the 'Buddhism and Wellbeing: Therapeutic Approaches to Human Flourishing'

before submitting this article resulted in some 65 million web links, including almost 1.2 million news items and 158,000 scholarly articles.[2] In my perusal of the highlights of this vast corpus, I have noted that both the outpouring of enthusiasm for the health benefits of meditation and the inevitable backlash that now seems to be in full swing have tended to discuss this topic primarily in terms of its relevance for contemporary life. It is clear that much of this discourse is fully embedded in the values and assumptions of Buddhist modernism, and represents a significant departure from historical Buddhist understandings.[3] This fact notwithstanding, behind the brain scans, Twitter feeds, and other high-tech trappings of the twenty-first century meditation craze lies a history of Buddhist engagement with health and wellbeing that is as old as the history of Buddhism itself.

This article represents the first step toward writing a *longue durée* global history of Buddhism and medicine over the course of two-plus millennia ('from Sarnath to Silicone Valley', one could say).[4] As a historian of medicine with a pervasive interest in Buddhist Studies, I am convinced that this topic remains one of the most significant unwritten chapters in both fields. To be sure, discrete examples of Buddhist healing in various times and places have long attracted the attention of scholars, and a sizable number of studies on particular texts, locations, and historical contexts have now been published.[5] However, to the best of my knowledge, pulling these diverse — often even disjointed — pieces together into a larger narrative on the global scale has yet to be attempted. Due to the constraints of space, I will not try to tell that entire story here. I will instead focus this paper more narrowly on the geographical area of Asia, the premodern era, and Buddhist engagement with physical rather than mental health. Even within these parameters, there is still an unwieldy amount of data, so I necessarily will paint my picture in broad strokes. Rather than dwell on any particular time or place in detail, I will instead concentrate on identifying broader patterns, focusing on three major areas: (1) the transmission and reception of texts and ideas across premodern Asia, (2) the networks of circulation facilitating such exchanges, and (3) the intersections between our topic and local and regional histories. I hope that by focusing on these three themes I will be able, even within this limited space, to situate our contemporary fascination with Buddhism and health within its larger historical context.

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conference at the University of British Columbia. I thank the participants in these various fora for their comments and suggestions.

2. The precise search term was: (buddhist health) | (buddhism health), searched on Google, Google News, and Google Scholar on 24 June 2015.

3. On Buddhist modernism, see especially McMahan 2008. For a recent history of the mindfulness movement in America, see Wilson 2014.

4. This is not the venue in which to adjudicate the meaning of the term 'medicine' and how it differs from 'health', 'healing', 'wellbeing', and so forth. In this article, I use the term 'medicine' loosely to point to ideas, practices, practitioners, and institutions developed with the interest of curing and preventing physical diseases. I use 'Buddhist medicine' or similar terms as a convenient way of referring to ideas and practices introduced in Buddhist texts, practiced by the *saṅgha*, and affiliated with Buddhist monastic institutions. See discussion of the emergence of this category in East Asia in Salguero 2015.

5. See overviews of the extant scholarship in Salguero 2014a, 2014b.

Transmission and reception

Medicine is a common concern in even the earliest extant Buddhist texts from India. This includes both the Pāli Canon, which first began to be written down in the first century BCE (though ostensibly based on an earlier oral tradition), as well as Sanskrit manuscripts from the early Common Era. The monastic codes of the early Indian schools, for example, contain entire sections dedicated to the medical procedures that were allowed and prohibited for the monastic community. Despite protestations that the *saṅgha* should not be involved in giving medical care to the general public, the same *vinaya* texts condone and even mandate monastics to provide physical and spiritual care for the sick among the order. Outside of the disciplinary literature, discussions of the anatomical contents of the body abound — particularly within meditation texts detailing the practice of *asubha-bhāvanā*, or the contemplation of the unpleasant and even loathsome nature of corporeal embodiment. Narratives describe medical and surgical interventions, most notably the Pāli and Sanskrit accounts of the procedures performed by the lay physician Jīvaka Kumārabhṛta (Pāli Komārabhacca). Early Mahāyāna *sūtra*s detail the ritual worship of deities such as Bhaiṣajyaguru, the 'Master of Medicines' Buddha. A more comprehensive list of sources, including all of these, is given in the appendix to this article. The point to make here is that medical knowledge of various types was embedded within the Buddhist tradition from the earliest times, and was an integral part of the spread of the religion across Asia.

It is apparent that this body of medical knowledge was never considered to be 'Buddhist' in India. The authors of Pāli and Sanskrit texts refrain from using sectarian labels such as 'Buddhist medicine'. Nor, incidentally, do they refer to 'Āyurveda'. Instead, they favor generic words such as *cikitsā* or *bhaiṣajya*, and tend not to credit the medical doctrines and practices they mention to any specific sectarian affiliation. This fact notwithstanding, recipients of these ideas and practices in the larger world beyond the Indian subcontinent often tended to closely associate this imported knowledge with Buddhism. There are some indications that explicitly non-Buddhist strands of Indian medicine were indeed recognized and valued abroad — including, for example, the incorporation of 'Brahmanical' practices into a handful of East Asian medical treatises[6] — however, Buddhism seems to have been the principal context in which Indian medicine was encountered beyond its area of cultural and geographical origin.

It is beyond the scope of this paper to discuss the spread of Buddhism throughout Asia in the first millennium CE in any detail, as this historical process is already copiously documented elsewhere.[7] Suffice it to say that Buddhist texts mentioning various aspects of medicine proliferated across the Buddhist world throughout the first millennium. Medical doctrine and practices are found in all manners of scriptures, disciplinary texts, ritual manuals, exegetical commentaries, and other canonical materials, as well as in a range of extracanonical writings whose connections with Buddhism are more tangential but just as illustrative.

6. See, e.g.: Salguero 2014c, 39; Hsia *et al.* 1986, 116–118.

7. On the spread of Buddhism along the trade routes, see, e.g.: Heirman and Bumbacher 2007; Neelis 2011; Sen 2014; Wong and Heldt 2014; and the special issues of *Diogenes* 43 (171), *Pacific World Third Series* 4, and *Sino-Platonic Papers* 222.

Such texts are extant today in whole and in part in Sanskrit, various Prakrits, Pāli, Chinese, Tibetan, Khotanese, Sogdian, Xixia, Mongolian, Uighur, and other languages from across Asia.

When reading across this vast literature, one finds much diversity of opinion. However, one also finds that Buddhist discourses on medicine tend to maintain a certain distinctive flavour. Some basic orienting perspectives can be identified that inform virtually all traditions — Theravada, Mahāyāna, and Vajrayāna — in the premodern period. Stripping these perspectives down to the most basic terms, we might think of the following points as constituting a blueprint of a particularly Buddhist approach to disease, healing, and the wellbeing of the body:

1. Illness is considered an inevitable aspect of human existence, but there is the possibility of escaping it through Buddhist insights or practices. At the very least, one who is detached from their body or realizes its empty nature is not troubled by its discomforts. To put the point a different way, Buddhism explicitly includes relief from the suffering of illness within the purview of the Dharma. The doctrine that the fourfold afflictions of birth, old age, sickness, and death are eradicated by Buddhist liberation is the most common formulation of this doctrine.
2. A corollary position is that the component parts that make up the body are inherently repulsive and mutually antagonistic, and it is for these reasons that discomfort, unease, and instability are the natural states of the human body — at least for unenlightened individuals who have not achieved mastery over the material world or cultivated superhuman bodies through ritual, visualization, or yogic practices.
3. While any number of factors may be identified as proximal causes of illness, it is non-liberation from karma that is the deeper reason for one's bodily discomforts from birth until death, and that is the deeper determinant of one's lifespan.
4. The entire repertoire of Buddhist ritual practices (e.g., making offerings, reciting scripture, prayers, chanting, *dhāraṇī*, talismans, image-making, exorcisms, esoteric rituals, etc.) can be employed or modified specifically for the purpose of curing disease, maintaining health, or extending the lifespan.
5. Caring for the sick is one of the chief ways to improve one's own karmic standing, and is a moral obligation for members of the monastic community. Which categories of sick people must be cared for differs in various Buddhist traditions: Pāli texts seem to suggest that caring for the laity is a violation of monastic discipline,[8] but many Mahāyāna texts advocate caring for the sick of all types. In certain esoteric or Vajrayāna traditions, this becomes an imperative to heal the entire cosmos.
6. Deities, enlightened individuals, and adept members of the *saṅgha* can control disease, health, and longevity — both of their own bodies and of the bodies of others — and these figures can be sought out or invoked by the devout in need of healing. Objects that have come in contact with, or

8. Ṭhānissaro 2007, 54.

are otherwise associated with, such beings can be empowered with their blessings and used to heal as well.

7. Moderation and moral restraint is good for one's health. This typically includes avoiding drastic changes and extremes of behavior, as well as maintaining proper ethical discipline (which explicitly includes upholding vegetarianism among many groups). On a related point, it is often necessary to regulate one's diet and regimen in accord with the seasons to maintain optimal health.
8. Negative mental or emotional states (often specifically attachment, hatred and delusion) also should be controlled, as they are among the key factors leading to illnesses of the body. Meditation or contemplation is an important method for conquering these, and thus maintaining mental and physical heath; however, excessive or improper meditation can itself lead to mental and physical illness.
9. Finally, medical metaphors (such as the Buddha being called the 'Great Physician' and the Dharma being called the 'Great Medicine') are routine ways of speaking. Such metaphors, plus an entire range of medical similes, analogies, and parables are frequently used for illustrating points of Buddhist doctrine.

There is no checklist that could adequately represent all of the health-related knowledge presented in all Buddhist texts across Asia; nor should we try to erect rigid boundaries to separate Buddhist versus non-Buddhist perspectives. Nor are all of the above points unique to Buddhist medical discourses (Āyurvedic texts also talk about karma, for example, and Chinese medicine stresses the ill effects of emotions).[9] Nevertheless, it can generally be said that the above doctrinal perspectives tend to predominate in Buddhist texts to a greater degree than in other traditions. They are often the very features that have struck recipient cultures as being novel about Buddhist teachings on illness and health, and they have remained durable parts of Asian Buddhist traditions up to the present.[10]

Another novelty about Buddhist writings on the above topics was that they frequently expressed these perspectives using specialized Indian medical terminology. The Great Elements (*mahābhūta, dhātu*), for example, are named as the main constitutive ingredients of the physical body, and there are meditations and rituals prescribed to manipulate them for healing purposes. The *tridoṣa* (lit., 'three defects': wind, bile, and phlegm) are named as principal causes of disease, and are often paired with negative mental states (attachment, hatred, delusion) that can be treated with Buddhist interventions. The power of particular medicinal flavours (*rasa*) to treat disease is mentioned in many texts, as is the correlation of both the onset of disease and the efficacy of the medicinal flavours with particular seasons (*ṛtu*) of the Indian year. Well-known Indian anatomical and physiological concepts — such as the seven bodily constituents (*saptadhātu*), vital points (*marman*), energy centers (*cakra*) and, channels (*nāḍī*), and the stages of

9. On *karma* in Āyurveda, see Weiss 1980. On emotions in Chinese medicine, see Sivin 1995.
10. This is not true, I would hasten to add, of contemporary, largely affluent and white forms of Western Buddhism. On the novelty and exoticism of Indian medical ideas in China being part of their appeal, see Salguero 2014c. See discussion of contemporary exegesis on these doctrines in Salguero 2015.

foetal development (*kalala, arbuda, peśi*, etc.) — also make frequent appearances in Buddhist texts.

On the face of it, Buddhism appears to have been one of the most important vehicles for the cross-cultural diffusion of Indian medicine in premodern Asia. The Indian medical knowledge contained in Buddhist texts was of substantial quantity and also was closely integrated into the core conceptual frameworks and practices of the Dharma. When we look more carefully at these texts and the ideas they contain, however, an oversimplified picture of Buddhism's influence abroad quickly breaks down. Despite the overarching similarities outlined above, it is readily evident that no single model was broadcasted from India to be simply or straightforwardly received in various parts of Asia. On the contrary, the extant texts seldom agree in the details of how they present Indian medicine — even when it comes to the most basic doctrines.[11] Some focus, for example, on the four Great Elements (earth, water, fire, and wind), while others discuss five (adding space) or six (adding space and consciousness). All texts recognize the standard three *doṣa* (wind, bile, and phlegm), but many treat the combination of the three (Skt. *sannipāta*) as a distinct fourth disease factor. Likewise, Buddhist texts diverge in how they understand the Elements or *doṣa* to be affected by the fluctuations of the seasons, diet and regimen, environmental factors, and specific pharmaceutical interventions. Finally, they differ in how they understand the efficacy of specific medicinal substances, as well as in how the medicinal flavours correlate with particular therapeutic effects. Taken collectively, these discrepancies give us the distinct impression that there were multiple conflicting transmissions circulating around Asia that differed both with each other as well as with the Āyurvedic classics, at least in the forms that those are available to us today.

Such diversity in the sources reminds us that the transmissions emanating from India were not like telegraph messages traveling from point A to point B along a straight line. While devotees conventionally considered Buddhist *sūtra*s to be authentic transmissions from India, much of the extant literature was in fact edited, compiled, or outright composed in Central Asia, Southeast Asia, or China.[12] While in transit, texts were encoded and re-encoded in various languages and a huge variety of scripts.[13] As they moved across geographical regions and were translated across linguistic and cultural boundaries, texts were constantly revised, recompiled, and rewritten. In the process, the medical ideas these texts contained were continually modified, elaborated, and reinterpreted. They were unbundled from Buddhist contexts, blended with indigenous medical concepts, and rebundled back into Buddhist writings.

Additionally, unique and locally-specific dynamics in all cases governed the reception of Buddhist medical knowledge in recipient cultures, and many of the discrepancies may be due to transformations texts underwent in the process of reception. As it turns out, many Buddhist 'translations' should more properly be thought of as 'transcreations' (i.e., combinations of translation and new composition) or even 'pseudotranslations' (i.e., new compositions that are written so as

11. Some of these discrepancies are discussed in Demiéville 1985.

12. On apocryphal texts in China, see Buswell 1990.

13. On Buddhist languages, see: Nattier 1990; Sinor 1995; Boucher 2008, 101–7.

to be passed off as translations).[14] While the echoes of Indian medicine are often clear in the extant versions of such texts, just as often they are quite garbled, encrusted with indigenous vocabularies and doctrinal accretions that are daunting, or even impossible, to trace back to India. Comparing multiple extant versions of texts from around Asia confirms that there are some common Buddhist orientations and therapies, but it also provides windows onto the active reconfiguration, adaptation, and localization of this transmitted Buddhist knowledge in order to suit local cultural and social contexts.[15] Such comparison reveals the complexities and historical contingencies behind the practices of adaptation in new languages and cultural contexts — not to mention the choices, preferences, strategies, and idiosyncrasies of individual historical actors. These processes of reception are important to understand and investigate on a case-by-case basis, and it is on this point especially that local, microhistorical, and biographical studies greatly enrich and complicate our global story.

Networks of circulation

Based on the discussion so far, it is evident that, despite some common overarching themes, our extant sources are best thought of not as part of a cohesive whole, but rather as a disparate collection of samples taken at various locations and points in time. When studied in the aggregate, however, these writings are like a scattergram of data-points that may hint at the shape of the overall patterns of circulation. I use the word 'pattern' here deliberately. For, if the currents of circulation of Buddhist knowledge do not always represent direct lines from A to B, neither were these movements simply random free-flows. Important centers of Buddhist learning and pilgrimage came in and out of prominence throughout the premodern period, and their rise and fall shaped and reshaped how information flowed across Asia. Some of these centers were especially famed as locations for medical training. One such place was Takṣaśilā (fl. third century BCE to fifth century CE) in Gandhāra, an Indo-Greek region that in the ancient period was a major confluence point for surgical, medical, and Buddhist learning (not to mention, a nexus for the funnelling of Greek culture and thought into India).[16] Perhaps the very pinnacle of learning was the 'Great Monastery' (*mahāvihāra*) of Nālandā (fl. fifth to twelfth centuries) in modern-day Bihar. Sometimes referred to as a monastic university, this institution's lecture halls and dormitories attracted students from across Asia to learn Buddhism and the so-called 'Five Sciences' (*pañcavidya*), which included medicine.[17] As Buddhism spread, important centers of

14. See discussion in Salguero 2014c.

15. Compare, for example, the legend of Jīvaka as told in Pāli, Sanskrit, Tibetan, and Chinese (Zysk 1998, 52–61; Salguero 2009). See additional examples of crosscultural comparative work in: Nobel 1951; Köhle unpublished ms.; and works by Chen Ming cited in the bibliography. Specifically on Chinese adaptations of Buddhist medicine, see Salguero 2010–11, 2013a, 2014c.

16. Among other distinctions, it was here that some said Jīvaka studied with Ātreya, the founder of Āyurveda (Zysk 1998, 55). See Naqvi 1991 on Gandhāran medicine and surgery; on Takṣaśilā specifically, pp. 52–66. On Takṣaśilā as a nexus point, see Fussman 1993.

17. It was at Nālandā that Vāgbhaṭa is said to have composed the *Aṣṭāṅgahṛdaya-saṃhitā,* the seminal medical treatise widely revered in both Āyurvedic and Buddhist circles. The Chinese pilgrim Yijing seems to have recognized the popularity of this text when he visited the monastery later in the same century (Vogel 1965, 8–10).

learning also emerged outside of India as well — including the Chinese capitals, Khotan, Dunhuang, Tibet, Ceylon, and Srivijaya among others.[18]

As would be expected in any institution housing a large number of people over the course of their lives, larger Buddhist monastic complexes often included special accommodations in which sick members of the *saṅgha* received medical, nursing, and hospice care.[19] Though caring for the laity was not condoned by all Buddhist communities, tending to one another within the monastic community was unequivocally encouraged.[20] Such care-taking gave the *saṅgha* ample opportunity and motivation to combine imported and local therapies, and the institutional contexts in which to accumulate oral and tacit knowledge of what was efficacious. More conservative monastic disciplinarians decried the pervasive blending of imported and indigenous medical therapies, arguing that the *saṅgha* should follow closely the 'pure' or 'original' teachings.[21] But, given the availability of medical knowledge from all over Asia at major monastic centers of learning — not to mention the multicultural backgrounds of the residents — these facilities were natural 'contact zones' or 'trading zones' that facilitated experimentation, syncretism, and hybridity.[22]

The most active centers of learning also functioned as 'centers of calculation' of sorts: nodal points to which translators and missionaries brought knowledge from around the Buddhist world to be analyzed, synthesised, repackaged, and disseminated onwards.[23] For example, between the second and eleventh centuries, texts were brought from across the Buddhist world to the major monasteries of the Chinese capitals. The translations and compositions produced at these locations — complete with all of the stylistic, ideological, and politically motivated adaptations mentioned in the previous section — were collected and disseminated via the Chinese canonical collections, and came to be enduring parts of the Chinese Buddhist landscape.[24] These same texts also were subsequently exported to Korea, Japan, and Vietnam, where they became the objects of further study and veneration in new cultural contexts. The same Chinese translations often also circulated to Tibet or Central Asia as well, to be re-translated once again into Tibetan, Uighur, Xixia, or Mongolian.[25]

18. On Dunhuang as a center of monastic medical education, see Despeux 2010.

19. See discussion of such facilities in: Demiéville 1985, 54–55; Zysk 1998, 44–6, 147–48 n. 41.

20. On the monastic restrictions against practising medicine on the laity, see: Demiéville 1985, 35–41; Langenberg 2014. The locus classicus of the doctrine that monks should care for one another is the story of the Buddha caring for a monk with dysentery. For the Pāli version, see translation in Horner 2000, 431–34 (*Vinaya* I.301–03); discussion in Zysk 1998, 41. The version from the Mūlasarvāstivāda *Vinaya* is discussed in Schopen 2004, 8. The Chinese is translated and discussed in Shinohara 2007, 107–8; see also Salguero 2014c, 124–25.

21. On Daoxuan's (596–667) efforts to regulate such practices, see Chen Huaiyu 2007, 159–62. See also discussion of Yijing's antisyncretic position on Buddhist medicine in Salguero 2014c, 112–16.

22. On 'contact zones', see: Pratt 1991; Somerville and Perkins 2003. On 'trading zones', see Gallison 1997; discussion in Fan 2012.

23. On 'centers of calculation', see Latour 1987.

24. On the compilation and circulation of the Chinese canons, see: Lancaster 2012; Orzech 2006; Hureau 2010.

25. See, e.g., patterns of transmission and translation for specific texts discussed in: Skjaervø 2004; Kara 2004.

It was not only texts. Also circulating widely across Asia were Indian medicinals — whether spices, aromatics, animal parts, minerals, or magically potent substances.[26] The movement of these substances was always closely tied to patterns of tribute and trade, and these flows were not necessarily the same as those of texts. Buddhists have invariably taken advantage of locally-available pharmaceutical substances, and in certain locations, Buddhist rituals and symbolism were integrated into flourishing local medicinal plant cultures. However, a rising population of Buddhists at any given place also stimulated local demand for foreign medicines of all kinds. Prominent Buddhist texts advocated the use of novel medicinals such as milk products, sugar, *harītakī*, *āmalaki*, *pippalī*, and black pepper as panaceas for curing all kinds of common ailments. Many Indian medicinal substances were prized specifically for their role in rituals. For example, major scriptures called for the use of medicines as offerings to Bhaiṣajyaguru or other deities, and medicinal substances were also sometimes inserted inside statues of these deities in order to consecrate or empower them.[27] Other texts call for the use of sweet flag, aloe, cinnamon, bdellium, sandal, realgar, saffron, long pepper, cardamom, butter, sesame oil, bezoar, and other common Indian medicinals in the performance of rites to strengthen, protect, and cure the devotee.[28]

In addition to texts and medicines, people themselves also circulated between Buddhist centers. Medieval Chinese records list individuals of Parthian, Yuezhi, Sogdian, Kuchean, Khotanese, Kashmiri, Indian, and Southeast Asian extraction all actively propagating Buddhism in China.[29] Our knowledge is most detailed in the case of a string of East Asian pilgrims who left travelogues and other records of their journeys to the holy lands.[30] The most famous — Faxian 法顯 (320?–420?), Xuanzang 玄奘 (602–664), Yijing 義淨 (635–713), and the Korean monk Hyecho 慧超 (704–787) — undertook voyages to locations such as Khotan, Takṣaśilā, Srivijaya, and Nālandā with the specific intention, they tell us in their own words, of acquiring Buddhist education and texts.

By no means did all — or even most — of this transcontinental travel involve medicine. However, we know that the movements of monastics did often contribute materially to the transcontinental circulation of medical ideas, objects, and practices. Traveling monks often attracted fame, fortune, and followers in new lands precisely due to their knowledge of healing methods. Narratives about foreign monks and their East Asian students feature prominently in a series of hagiographies of 'eminent monks' from China and Korea.[31] These collections retell the wondrous healing accomplishments exotic Buddhist practitioners supposedly performed on behalf of rulers, the elite, and the common population alike. In a less fantastical vein, reportage in Faxian's and Xuanzang's travelogues intro-

26. On medicinals as trade and tribute, see: Schafer 1963, 176–94; Bielenstein 2005; Chen Ming 2007, 2013.

27. On Bhaiṣajyaguru rites, see Birnbaum 1989a. On statues, see: Okuda et al. 2005; Robson 2014.

28. See translations of such texts in: Emmerick 2004, 44–49; Kara 2004; Unschuld 2010, 314–21.

29. These individuals are detailed in Zürcher 2012.

30. See translations of these accounts in: Giles 1923, Takakusu 1966; Li 1996, 2000.

31. Salguero 2010, 2014c: 133–39; see also relevant entries in Fu and Ni 1996. For translation of the Korean compilation, see Ha and Mintz 1972. For discussion of the genre more generally, see Kieschnick 1997.

duced China to Indian hospitals and the medical charity of Indian kings.[32] Yijing's account, dispatched back home to China while he was still abroad, is by far the most detailed on such matters. It includes multiple chapters detailing Indian monastic practices concerning health, medication, and personal hygiene.[33]

It is worth underscoring that this monastic travel was multi-directional, and did not necessarily always privilege India. Among the travellers whose movements have been studied by scholars is Puṇyodaya (fl. mid seventh century), a Tantric master from Central India who studied in Sri Lanka. Shortly after arriving at the Chinese capital in 655, he was dispatched by the emperor to Zhenla (modern Cambodia) in order to gather texts and medicines.[34] The Japanese monk Kūkai (774–835), on the other hand, spent two years in China studying esoteric Buddhism, and brought home the *kaji* 加持 empowerment rituals that would become a mainstay of healing ritual practice in Japan into modern times.[35] His contemporary Saichō (767–822), after a similar trip, played a major role in reshaping the Japanese cult of Bhaiṣajyaguru.[36] Several centuries later, the Vietnamese monk Tuệ Tĩnh 慧靖 (ca. 1330–1389) was sent by the Trần Dynasty (1225–1400) to the imperial court of the Ming as a gift of tribute. During his stay in China, he wrote the first text advocating the medical traditions of southern Vietnam in the classical Chinese language.[37]

From the middle of the first millennium onwards, such translators, missionaries, pilgrims, and other travellers increasingly circulated between centers of learning and connected those centers with the peripheries of the Buddhist world. This group constituted a cosmopolitan and polyglot intelligentsia that one scholar has dubbed the 'Buddhist international'.[38] While, of course, Buddhist texts provided important authoritative statements about medical doctrine and ideology, it is clear that much of the actual practice must have been the product of thousands upon thousands of discrete moments of contact and exchange of written, oral, and tacit knowledge between individuals in these multicultural social networks.

Intersections with local and regional histories

All things considered, many of the monks discussed in the previous section likely would have felt stronger allegiance to the network itself than to any particular ruler or regime. Nevertheless, Buddhism's success in any given location was invariably tied to local politics. Buddhist institutions and individuals received periodic boosts in support from enthusiastic rulers, and sometimes such patronage was specifically aimed at stimulating the circulation of medical knowledge. The pen-

32. Faxian's comments are translated in Giles 1923, 47–8. Xuanzang's comments are translated in Li 1996, 144.

33. Translations of this text are available in: Takakusu 1966; Li 2000. Information relevant to medicine is found especially in Chapters 4–8, 18, 20, 23, and 27–29. Studies on the medical contents of this text include: Liétard 1902; Reddy 1938; Devi 1979; Salguero 2014c, 112–16.

34. Lin 1935.

35. On *kaji*, see: Winfield 2005; Josephson 2010.

36. On the history of the Bhaiṣajyaguru cult in medieval Japan, see Suzuki 2012.

37. Biographical details available in Thompson unpublished ms.

38. On the term 'Buddhist international', see Adshead 2000, 102.

chant of some Chinese emperors for bringing Buddhist healers and ritual specialists into the court to cure themselves and to protect the realm from epidemics is well attested.[39] One of the most enthusiastic proponents of Buddhist-inspired medicine anywhere was the Tibetan regent Desi Sangyé Gyatso (1653–1705). He reedited the seminal Tibetan medical *tantra*s (*rGyud bzhi*);[40] produced the *Blue Beryl* (*Baidurya sngon po*), a four-volume commentary on the *tantra*s that included a set of 79 *thangka*s illustrating the entirety of Tibetan medical culture;[41] and composed the first comprehensive history of medicine in Tibet, which gave pride of place to Buddhism.[42] The Desi did not defer to Buddhist authority on all points, and Tibetan medicine clearly originates from a combination of historical sources in addition to Buddhist thought.[43] However, as he makes clear in his writings, he saw the practice of medicine (indeed of all of the 'Five Sciences') as integral to the path of the *bodhisattva*, and he also was well aware of its potential role in the legitimation of his government.

Supportive and savvy rulers also played a pivotal role in the expansion of networks of Buddhist institutions at the local level. Buddhist medical charities were opportunities for kings to prove their generosity to their populations.[44] Many rulers across Asia fashioned themselves as 'wheel-turning' monarchs (Skt. *cakravartin*) on the model of the idealized Mauryan ruler Aśoka (r. ca. 269–232 BCE), a renowned supporter of Buddhist and medical charity.[45] In China, the first permanent public hospitals, hospices, and dispensaries for which there is historical record were established in the late fifth and early sixth centuries by Buddhist rulers.[46] By the first decade of the eighth century, an empire-wide network of monastic charities — which by that time included not only hospitals, but leprosaria, orphanages, hostels for travellers, and care for the elderly and the poor — came under the centralized administrative control of the government bureaucracy.[47] It is not coincidental that the ruler at this time was Empress Wu Zetian, who astutely mobilized Buddhist ideology (including presenting herself as a reincarnation of Maitreya Bodhisattva) in an effort to legitimize the rule of the empire by a woman.

39. Such events are discussed in, e.g. : Sen 2001; 2003, 44–53.

40. A Tibetan medical compendium, written in the style of a Buddhist *sūtra* but not included in the canon. Probably dating from the twelfth century, it was reedited in the late seventeenth century by Sangyé Gyatso and continues today to constitute the foundational treatise of Tibetan medicine. Partially translated in Clark 1995; see discussion in Fenner 1996.

41. See reproduction of *thangka*s with translations of textual content in Williamson and Young 2009; originals in Parfionovitch et al. 1992.

42. Translation of this text is available in Kilty 2010.

43. See discussion of the Desi's approach to Buddhism and medicine in: Schaeffer 2003; Gyatso 2015.

44. Some such projects are introduced in Demiéville 1985, 56–63.

45. While the historical Aśoka's connections with Buddhism are more tenuous (Norman 2006: 147–69), the Aśoka of Buddhist legend was a magnanimous donor to the *saṅgha*, including gifts of medicine. See translation of the Chinese version of the Aśoka legend in Li 1993. Strong 1983 discusses and translates the Sanskrit version, and see his pp. 38–70 for general discussion of Aśokan models of kingship in India.

46. These are briefly outlined in Needham 2000, 54.

47. See discussion of these institutions in: Ch'en 1973, 297–301; Gernet 1995,221–23.

Likewise, in the late twelfth century, the Khmer king Jayavarman VII built a network of over 100 *ārogyaśālā,* or 'health-houses' across his kingdom.[48] Adorned with statues of Bhaiṣajyaguru and attendant *bodhisattva*s, and staffed by monastic healers specializing in herbal medicine, Jayavarman's hospitals have been interpreted as an integral part of an effort to win the 'hearts and minds' of his population, particularly in newly-acquired territories to the west of the kingdom. As late as the early 1800s, when the newly crowned kings of Siam were renovating Bangkok's royal temple, Wat Phra Chetuphon, they installed statues depicting health-bestowing *yoga* postures, stone inscriptions bearing herbal formulas, and marble tablets depicting the Thai system of points and meridians (Th. *sen*).[49] This knowledge, attributed to the legendary physician Jīvaka and other Buddhist sages, was specifically conceived as a 'donation of medicine', intended both to increase the merit of the king and for the education, benefit, and unity of the population.

The relationship with rulers was not always so rosy: as they grew in importance and wealth, Buddhist institutions inevitably also came into conflict with secular powers. The *saṅgha*'s power was periodically checked by political shifts in various parts of the Buddhist world, which sometimes resulted in the disappearance of certain nodes of medical learning and disruptions in networks of circulation. For example, as I have explored elsewhere, Indian medical knowledge receded in importance in Chinese official circles from the mid-ninth century onwards due to a combination in the rise in neoclassical and anti-foreign sentiments and the government's choices of texts to utilize in the standardization of imperial medical training.[50] The preference for Hinduism over Buddhism in sixth century Zhenla or for neo-Confucianism in sixteenth century Korea had similarly stultifying effects.[51] Across Asia, the permanent abandonment or destruction of many Buddhist centers of learning took place during the process of Islamization, which affected much of the Silk Roads by the ninth century, northern India by the twelfth, and Java in the fourteenth.[52] Nālandā itself was razed and its library burned by Muslim armies around the year 1200.

While the long-term influence of Buddhism on local histories of medicine varied by circumstances such as these, regionally we can identify three general trajectories. The first pertains in those parts of Central Asia, north western India, and far western China that were early Buddhist strongholds but that converted to Islam or Hinduism beginning in the last quarter of the first millennium. There was much crosspollination between Buddhist, Hindu, and Islamic medicine in these regions, but as Buddhism was suppressed or died out, along with it went most of the practice of explicitly Buddhist medicine.[53] Nonetheless, important

48. Jayavarman's medical charities are discussed in: Jacques 1968; Chhem 2005, 2007; Sharrock unpublished ms.

49. The artefacts and texts produced at Wat Po are discussed in: Nivat 1933; Griswold 1965; Mulholland 1987, 1–38.

50. Salguero 2014c, 141–145. See discussion of the standardization of medical training in Goldschmidt 2009.

51. See, respectively: Sharrock unpublished ms; Baker 1994.

52. See discussion of interactions between Islam and Buddhism in Elverskog 2010.

53. Note that both Āyurveda and the Islamic medical tradition 'Unani' (meaning 'Greek') are related to Greco-Roman medicine, and hence close cousins of Buddhist medicine. Thus, this

archaeological sites in the region such as Gilgit, Gandhāra, and Kucha still have given us some of our most important archaeological evidence for its early diffusion, and points to its significant influence earlier in the history of these regions.

A second, quite different, trajectory pertained in East Asia, where proponents of Indian methods had to contend with a codified, literate medical system attached to Chinese imperial ideology. Despite a palpable level of fascination with Indian medicine in the medieval period, in the long term, Buddhist medical models remained subordinate to native Chinese ideas in this part of the world.[54] Indian concepts were often explained in terms of the normative language of Chinese medicine (i.e., *qi, yinyang*, etc.), and overall the influence of Indian medicine remained limited to those particular aspects that could fit into domestic frameworks of thought and practice.[55] As the rest of East Asia largely received Buddhism via China, Chinese translations and interpretive decisions often determined in large part how Indian ideas would be presented in Korea, Japan, and Vietnam. Although Buddhist therapeutics (notably including esoteric healing rituals) seem to have been more prevalent in Japan than elsewhere in East Asia, even there the overall impact of Indian medical doctrine on the medical landscape was minimal when compared with the influence of secular Chinese medicine.[56] Make no mistake: Buddhism was, and is to this day, intimately integrated with healing practices of all kinds in most parts of East Asia. On the whole, however, it seems that that much of the substance of Indian healing was omitted in East Asia, and the general orientations outlined in the first section of this paper were instead grafted onto native interventions such as acupuncture, herbs, and the arts of *qi*.

Finally, a third general trajectory characterizes the non-Islamized parts of Central and Southeast Asia, where the Buddhist inheritance formed the nucleus for the subsequent development of local traditions of medicine that still thrive today. These regions include Tibet, Nepal, Bhutan, Mongolia, Sri Lanka, Thailand, Myanmar, Laos, and certain pockets of related peoples inside the modern borders of India, China, and Russia. In some of these places, varying amounts of Chinese medical influence can be detected. Imported Indian models also competed and eventually blended with local traditions of shamanism and spirit-healing. However, it is basic Indian ideas such as the Elements and the *tridoṣa* that constitute the core doctrines of contemporary traditional medicine in these parts of Asia. The founding myths and rituals of traditional medicine practitioners in these cultures continue to revolve around venerating Buddhist deities and heroes as founders and patriarchs of the tradition.[57] Many of the key texts that make

transition may not have been abrupt, and it may even have been unnoticeable to a non-specialist resident of that region. Note that I am using the anachronistic word 'Hinduism' as a term of convenience in this paragraph.

54. On medieval Chinese Buddhist medicine, see, inter alia: Birnbaum 1989b; Davis 2001; Strickmann 2002; Despeux 2010; Chen Ming 2013; Salguero 2013a, 2014c.

55. Salguero 2014c, 141–145; cf. Unschuld 2010: 132–153.

56. On Japanese Buddhist medicine, see, e.g. : Winfield 2005; Goble 2009, 2011; Triplett 2012, 2014.

57. A *mandala* depicting a number of Buddhist deities and heroes among the patriarchs of Tibetan medicine appears among the 'Blue Beryl *thangkas*' (reproduced in Williamson and Young 2009, 16). See also discussion of a contemporary Tibetan medicine ritual in Garrett 2009; and of Mongolian Buddhist-inspired medicine in Wallace 2012. A description of a Thai ritual venerating Jīvaka as founder of the Thai medical tradition is presented in Salguero forthcoming.

up the medical canons are attributed to famous Buddhist authors. A package of Indian Buddhist therapies — including talismans, amulets, chanting, incantations, Indian astrology, exorcisms, empowerments, binding rites, consecrated water or medicines, and so forth — form the basis of the ritual repertoire of healers across these regions. Much of the language used in talking about these practices, as well as the material culture, is also quite obviously Buddhist in origin.

Conclusion

Today, Wat Phra Chetuphon still houses its medical artefacts, and these have become a major tourist attraction in Bangkok.[58] Materials compiled and codified at the temple in the nineteenth century are still utilized in the training of physicians in government-licensed Thai Traditional Medicine (*phaet phaen thai*) schools across the country. Under the aegis of the World Health Organization and other international organizations, aspects of scientific medicine have increasingly been integrated into the traditional medicine curriculum.[59] Particular aspects of herbal medicine and massage have also begun to receive increasing attention from clinical researchers, and studies of these practices now appear periodically in scientific journals.[60] Despite these signs of modernization, however, Buddhist ideas, practices, and institutions have remained at the heart of the everyday practice of traditional medicine, even within official circles.[61] This continuing explicit and government-promoted connection with Buddhism is one of the most obvious points of distinction between traditional Thai medicine and other more secular systems such as contemporary Ayurveda and TCM.

Tibetan medicine (*Ggso ba rig pa*), historically influential in Tibet, Bhutan, Nepal, Mongolia, and parts of Northern India, now is also widely practiced among Tibetans in diaspora and non-Tibetan aficionados across the modern world. Practitioners have varied in their understandings of the relationship between Buddhism and Tibetan medicine over the history of this tradition.[62] Nevertheless, today, the leading organization promoting Tibetan medicine globally, the Men-Tsee-Khang, prominently displays an image of the Medicine Buddha on its website banner and includes *mantra*s associated with this deity in its instructions for the use of medicines and other therapies listed on the site.[63] American museums affiliated with the Tibetan community have periodically organized exhibits of Tibetan medicine that showcase Buddhist texts, artefacts, and material culture, highlighting their historical role in Tibetan healing traditions.[64] The current Dalai Lama and other Tibetan Buddhist luminaries have maintained high profiles in the

58. See http://www.watpho.com, accessed 5 Mar. 2015.

59. See, e.g., Chuthaputti and Boonterm 2010.

60. A search on PubMed.org for the phrase '(thai massage) OR (traditional thai medicine)' on 9 Mar. 2015 resulted in 749 articles — far fewer than for Chinese medicine or Āyurveda, but still not an insignificant number.

61. See, e.g. : Gosling 1985; Ratanakul 2004; Chokevivat and Chuthaputti 2005; Salguero forthcoming.

62. See Gyatso 2015 for a discussion of early modern debates.

63. See http://www.men-tsee-khang.org, accessed 9 Mar. 2015.

64. Recent publications associated with such exhibits include: Williamson and Young 2009; Hofer 2014.

contemporary dialogue between Buddhism and science, and routinely appear at or organize conferences focusing on health-related topics.[65]

Buddhist and Buddhist-inspired healing continues to play a major role in the contemporary health care landscape in other places around Asia as well, although often with less attention from Western enthusiasts and researchers than is the case with Thai and Tibetan medicine. Many proponents of these traditions are actively interfacing with modern science and biomedicine; however, they also continue to frame their medical traditions as in large part deriving from Buddhist deities, texts, and ideas.[66] Such overtures, I argue, are not mere window-dressing. Despite the fact that Buddhism rarely receives much attention in general accounts of the history of medicine or vice versa, these are living reminders of the fundamental role Buddhism played in the circulation of medical ideas and practices across a huge swathe of territory, from Persia to Japan and from Siberia to Java, in the premodern period. These are the tangible traces of Buddhism's intimate involvement across the region in the reception and development of medical knowledge, in matters of medical legitimation and authority, and in the identity and values of healers.

To conclude, I will come back full circle to where we began, with the ubiquitous references to meditation and health that predominate in the academic, scientific, and popular media today. I am not saying that there is nothing new here, or that there are not significant ruptures with the past. Certainly, there is and there are. Nevertheless, I will observe that, when seen from the *longue durée* global perspective, many of the dominant themes in this conversation seem to be revisiting some of the very same issues that have arisen again and again in discourses about Buddhism and medicine throughout history, and these are worth examining in historical perspective. What are Buddhism's core teachings about health and wellbeing, and how are these being transformed by processes of cross-cultural translation? How do key institutions, social networks, and the transnational flows of information between them influence the circulation and adoption of these ideas and practices? How do local and international political and economic interests shape their implementation over the long term? How is their reception affected by cultural preferences, inter-religious competition, and stereotypes about the exoticised Other? These questions — which have become so salient today thanks to the meditation revolution — are not necessarily novel dilemmas of the twenty-first century. Rather, in many ways, these are the perennial questions of a millennia-long historical narrative that has played out, and continues to unfold, on a global stage.

65. See, http://www.mindandlife.org, accessed 9 Mar. 2015.

66. This statement is partly based on my own as yet unpublished research interviewing Buddhist and Buddhist-inspired healers. For published descriptions of contemporary Buddhist healing in various other Asian and immigrant contexts, see, e.g. : Dietrich 1996; Deck 2002; Wu 2002; Numrich 2005; Wangchuk *et al.* 2007.

Appendix: overview of relevant historical texts

The following list outlines various textual genres that are relevant to the study of the history of Buddhism and medicine in the premodern period, with citations to existing scholarship and translations:

1. Major scriptures: These are sacred texts with pan-Asian importance and circulation. For example, one chapter of the *Saddharma-puṇḍarīka-sūtra* introduces the *bodhisattva* saviour-deity Bhaiṣajyarāja ('Medicine King'), an important object of worship and contemplation.[67] The *Bhaiṣajyaguru-sūtra* details the previous lives and vows of the related buddha Bhaiṣajyaguru ('Master of Medicines'), as well as the rites that can be carried out in order to save oneself from disease and untimely death.[68] The *Suvarṇa-prabhāsottama-sūtra* contains a chapter that outlines the basic doctrine of *tridoṣa*, including the correlations among these defects, the arising of illnesses, the seasons of the year, and the medicinal flavours (Skt. *rasa*).[69] Another chapter from the same text prescribes a ritual for invoking the protection and healing of the goddess Sarasvatī by bathing with 32 different aromatic medicines, making offerings, and chanting *dhāraṇī*. Other major scriptures, such as the Mahāyāna *Mahāparinirvāṇa-sūtra,* have shorter sections that deal with medicine in a metaphorical way or as a heuristic device for understanding Buddhist teachings.[70] All of these texts are extant in various editions and languages from across the Buddhist world, and served as major focal points for devotion, exegesis, and commentarial literature in a great variety of languages and locations.
2. Monastic disciplinary texts: Developed by the early Indian Buddhist schools and translated into various languages across Asia, monastic disciplinary texts invariably contain a section of rules (*Bhaiṣajya-skandhaka*) about the collection, storage, and provisioning of medicines that pertained to a particular monastic community.[71] These sections often give

67. This chapter is translated in Watson 1993, 280–289. Chinese texts and visualizations practices associated with Bhaiṣajyarāja are described in Birnbaum 1989a.

68. The Sanskrit versions of the text that were archaeologically recovered from Gilgit are discussed and translated in Schopen 1978; the Chinese versions in Birnbaum 1989a.

69. The various versions of this text are available complete or in fragments in Sanskrit, Chinese, Sogdian, Xixia, Mongolian, Uighur, Khotanese, and Tibetan. The Sanskrit is translated in Emmerick 2004; the Khotanese in Skjaervø 2004; both Chinese versions in Salguero 2013b. The medical information the *sūtra* contains comes in the form of oral instructions given by a lay physician to his son on the 'practice of medicine' or the 'science of medicine' (*yifang* 醫方 or *yiming* 醫明). On the face of it, it seems to me that the *sūtra*'s medical content should not be understood as Buddhist per se, but rather as a summary of secular Indian medicine. Nevertheless, this chapter is frequently cited by scholars and exegetes alike as a foundational Buddhist medical text.

70. Excerpts of this and other texts are discussed in Demiéville 1985.

71. See discussion of structure and contents of the various *Vinaya*s in Frauwallner 1956; of their transmission from India in Heirmann and Bumbacher 2007. For short translations of scattered passages concerning medical knowledge and practice from a range of *vinaya* texts, see Demiéville 1985. For a complete translation of the Pāli *Vinaya*'s section on medicine, see Horner 2000: 269–350 (*Vinaya* I 199–252); discussion in Ṭhānissaro 2007, 54–68, and Zysk 1998. See complete French translation of the Mahīśāsaka *Vinaya*'s medical section in Jaworski 1927.

a sense of the treatments that were used in ancient India for common disorders, and many points of discipline are illustrated with a founding story that presents these practices in narrative form.[72] In addition to the *vinaya* texts introduced from India, monastic disciplinary treatises composed domestically in various parts of Buddhist Asia contain much information on the local understanding, implementation, and adaptation of such knowledge.[73]

3. Manuals for healing rituals: Texts giving instructions on how to invoke divine or spiritual assistance for conquering diseases or maintaining health, as well as how to perform exorcistic rites and incantations to dispel demons or to treat particular ailments.[74] One important example is a version of the '*Dhāraṇī* of Great Compassion' (*Mahākaruṇā-dhāraṇī*) of the Thousand-armed, Thousand-eyed Avalokiteśvara (Ch. Guanyin) that contains a number of recipes for the treatment of specific ailments appended to the core *sūtra*.[75] The text instructs the officiant in the use of incantations to call upon Avalokiteśvara to empower the prepared medicines before they are administered to the patient. Other ritual healing texts can be exoteric or esoteric, *sūtra* or *tantra*, and can involve interactions with buddhas, *bodhisattva*s, protector deities, or local nature-spirits and demonic entities that were co-opted into the Buddhist pantheon in India or abroad. A subset of these texts give instructions on how to treat ailments with meditation, as well as how to counter the negative effects of meditation itself, which was widely acknowledged to be potentially dangerous for one's health.[76]
4. Buddhist medical treatises: Medical texts (regardless of their origin) that were incorporated into Buddhist canonical collections. There are, for example, 22 Indian medical texts that have been included in various editions of the Tibetan *Tengyur*[77] — including the *Aṣṭāṅgahṛdaya-saṃhitā*,[78]

72. One of the most significant examples of the latter is the lengthy biography of the physician Jīvaka, which recounts his life, training, and medical and surgical interventions. Multiple versions of this narrative are extant in Pāli, Sanskrit, Chinese, and Tibetan. See translations of the Pāli in Horner 2000, 379–398 (*Vinaya* I 268–281); of the Tibetan in von Schiefner 1906, 75–109; French translation of the Chinese in Chavannes 1962 vol. 3, 325–61; discussion of Jīvaka across cultures in Zysk 1998, 52–61, and Salguero 2009.

73. See discussion of Chinese reception of certain *vinaya* passages in Salguero 2015.

74. See discussion of such texts in Strickmann 2002; Orzech *et al.* 2011, 208–214.

75. This text is extant in the Chinese, Tibetan, and Mongolian Buddhist canons, as well as in a manuscript fragment written in Old Tibetan from Turfan. See translation of the Tibetan in Kara 2004, and of a related Chinese text in Unschuld 2010, 314–321.

76. See discussion of meditation sickness and of Chinese texts to treat it in Greene 2012. Another Chinese example is a series of texts by Zhiyi 智顗 (538–597) (T. 1911.7.3; T. 1915.9; T. 1916.4.4), all three of which include significant sections that introduce Indian and Chinese meditations and breathing practices for the eradication of specific symptoms arising within meditation. Translation of the relevant chapter from Zhiyi's shorter treatise can be found in Salguero 2012. Some of Zhiyi's medical thought is also discussed in: Demiéville 1985; Birnbaum 1989b.

77. Cordier 1903; Dash 1985, 9–16. See discussion of authorship and contents of specific Indian medical treatises in Meulenbeld 1999–2002.

78. A synthesis of the medical approaches of the *Caraka-saṃhitā* and *Śusruta-saṃhitā* written by Vāgbhata in the early seventh century, this compendium was disseminated widely and was

Siddhasāra,[79] and *Yogaśataka*.[80] Other major examples include the *Kāśyapa-saṃhitā* and *Rāvaṇakumāra-tantra* (Indian medical texts that were incorporated into the Chinese canon),[81] and the various extant recensions of the *Garbhāvakrānti-sūtra* (a Buddhist version of a text on foetal development that circulated in a number of Indian medical and religious contexts, now found in both the Chinese and Tibetan canons).[82] Today, these texts or fragments thereof are extant in and outside of Buddhist canons in languages as varied as Sanskrit, Chinese, Tibetan, Uighur, Cambodian, Tamil, and Arabic — which attests to their importance and circulation.

5. Other canonical texts: There are many other types of canonical Buddhist texts that are relevant to the study of medicine. *Vinaya* narratives have been mentioned above, but other narrative genres offer depictions of the Buddha, deities, and members of the *saṅgha* as healers.[83] Buddhist philosophical treatises often purport to explain how illness and recovery work, and how health is related to various doctrines such as *karma*, dependent origination (*pratītyasamutpāda*), and emptiness (*śūnyatā*). Important examples of texts in this category include certain Pāli texts that deal with various aspects of medicine,[84] a chapter of the *Vimalakīrti-nirdeśa-sūtra* that introduces the basic Mahāyāna philosophical position on illness as empty,[85] as well as a series of texts on the path or stages of spiritual development (including the *Vimuttimagga*, *Visuddhimagga*, *Yogācārabhūmi-śāstra*, and others) that describes the origin and makeup of the body as well as its relationship to the mind, making frequent reference to Indian medical doctrines.[86]
6. Extracanonical texts: Texts that remained unintegrated into the Buddhist canons but that attribute themselves to, quote extensively from, or otherwise bear witness to Buddhist medical knowledge. These include the

translated into multiple languages. It became a foundational text for both Āyurveda and Tibetan medicine, and certainly qualifies as the most influential Indian medical treatise in history. The Tengyur includes the root text, as well as four commentaries on it, including an auto-commentary attributed to Vāgbhaṭa that is not extant in Sanskrit. See discussion of text and partial translations in: Wujastyk 2003, 193–251; Vogel 1965; on the Uighur version, Maue 2008.

79. A seventh-century Indian medical text that is also available in Uighur. See translation in Emmerick 1982; discussion in: Emmerick 1971, 1974; Chen Ming 2002; Zieme 2007.
80. A practical manual that is traditionally attributed to the Buddhist philosopher Nāgārjuna, but which also likely dates to the seventh century. See Filliozat 1979; Dash 1985.
81. Translated in Bagchi 2011, 1941. See discussion in: Filliozat 1935, 1937; Wujastyk 1998a, 1998b, 2003, 163–189.
82. Translated in Kritzer 2014. See discussion and translation of various other versions in: Kapani 1989; Garrett 2008; Langenberg 2008; Kritzer 2009.
83. See discussion and some translation of East Asian healing narratives in: Wright 1948; Ha and Mintz 1972; Shinohara 2007; Salguero 2010, 2014c, 133–39; Campany 2012.
84. See, e.g., *Aṅguttara Nikāya* 10.60 (V.108–112), *Majjhima Nikāya* 28 and 62 (I. 184–191 and 420–426), *Saṃyutta Nikāya* 36.21 (IV.229–231), and various passages in the *Milindapañhā*, all of which are available in multiple translations in print and online. The Pāli literature related to medicine is summarized in: Mitra 1985; Mazars 2008.
85. Translated in Watson 1997, 64–74.
86. See: Ehara et al. 1962; Ñāṇamoli 1999; Lusthaus 2013.

Bower Manuscript[87] and *Jīvakapustaka*,[88] two medical manuals recovered from Buddhist sites on the Silk Road; various East Asian medical treatises that contain certain Indian teachings on ethics, massage, recipes, and surgery;[89] the *Bhesajjamañjūsā*, a text from Ceylon that is closely related to the *Aṣṭāṅgahṛdaya-saṃhitā* and the only extant medical treatise written in Pāli;[90] and the abovementioned works written or edited by Sangyé Gyatso.[91] We might also include in this category the huge quantities of historical records, popular narratives, poetry, and other miscellaneous writings from across Asia that mention Buddhist healers or therapies, whether approvingly or disapprovingly, in detail or in passing.

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87. An untitled sixth century birch bark compilation made in a Kuchean Buddhist monastery that includes texts on divination, incantation, and medicine. See: Saha 1985; Hoernle 1987; Wujastyk 2003, 147–160; Naqvi 2011, 83–92.

88. A text dated between the seventh and eleventh century attributed to Jīvaka, written in alternating Sanskrit and Khotanese. See: Hoernle 1917; Emmerick 1979; Chen Ming 2005.

89. The Chinese sources are briefly summarized in Salguero 2014c, 40. For discussion of the Buddhist materials in the Japanese medical text *Ishinpō* 医心方, see Triplet 2012, 70–73. See translations of relevant materials in: Deshpande and Fan 2012; Hsia *et al.* 1986, 116–118.

90. See Liyanaratne 2002–2009.

91. Some of these texts are discussed and translated in: Clark 1995; Fenner 1996; Schaeffer 2003; Kilty 2010; Gyatso 2015.

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