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Religion, Suffering, and Healing: Therapeutic Authority and Ritual Efficacy in Comparative Perspective

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Abstract

Illness poses questions about more than whether a treatment works: it also raises problems of responsibility, religious authorization, and the interpretation of improvement or continuing suffering. This article compares selected Śvetāmbara Jain monastic materials, the Buddhist Vinaya's account of care for a sick monk, and the Carakasamhitā's classification of treatment, with supplementary attention to healing narratives and documented contemporary practice. It argues that obligations to provide care, judgments about appropriate therapeutic means, and claims about efficacy constitute related but nonidentical forms of authority. The comparison challenges a simple opposition between religious and medical healing while refusing to infer clinical outcomes from prescriptive or narrative texts. Its contribution is a source-bounded account of what different kinds of healing evidence can establish.

Key-words - *religious healing; Jainism; Buddhism; Carakasamhitā; therapeutic authority; ritual efficacy; medical pluralis.*

Introduction: What Is Authorized When Healing Is Authorized?

Illness does not always become a religious problem because a particular community attributes it to a supernatural cause. It may become one because a religious institution must decide whether a sick member should be assisted, because specialists disagree about what sort of intervention is permissible, or because narratives represent relief from suffering as evidence of religious power. These are not interchangeable problems. A rule requiring members of a monastic community to care for the sick does not establish that the community claims exclusive therapeutic expertise. A classification that includes a ritual intervention among permitted treatments does not prove that it cures a specified disease. A narrative in which an extraordinary person heals an afflicted individual may assert authority without recording an independently verified clinical result. The analytical difficulty is not simply to identify religious healing but to determine what a particular source asks its audience to acknowledge.

The issue is acute in the study of Jain, Buddhist, and Hindu materials because their histories contain elaborate disciplines of suffering, extensive medical knowledge, rules of caregiving, devotional practices, and accounts of miraculous cures. It is tempting to arrange these in a historical sequence from religious renunciation to medicine, or to imagine one tension between spiritual liberation and physical relief. Neither arrangement is

adequate. A monastic rule can require mundane treatment in a community committed to renunciation. A medical treatise can include ritual and medicinal procedures in a single taxonomy. A devotional healing practice can draw on established religious literature while being organized through relatively new forms of instruction and publicity. The object called 'healing' thus changes with the sort of evidence used to approach it.

This article asks how illness, suffering, therapeutic efficacy, and the authority to heal are understood and negotiated in selected religious settings. Its central thesis is deliberately limited. In the sources examined, authority to respond to illness operates through at least three analytically separable questions: **who has an obligation or recognized standing to intervene; which means are treated as appropriate; and what warrants an interpretation that healing has occurred or that an intervention possesses efficacy.** These questions often intersect, but the sources do not resolve them through a common theory. The distinction is a procedure for disciplined comparison rather than the discovery of a previously unknown Indic doctrine. A more general claim that Indian religions have long combined medical and religious understandings of illness is already well established.

The principal primary textual settings are the Jain monastic regulations analyzed by Mari Jyväsjärvi Stuart (2014), especially the later Śvetāmbara commentarial discussions of treatment; the Pāli Vinaya's account of a

neglected sick monk and the qualifications of attendants in Mahāvagga VIII.26; and the threefold account of therapy in the Carakasamhitā, Sūtrasthāna 11.54. These materials have unequal documentary status. The Buddhist rule and the Sanskrit medical classification have been checked directly against accessible published textual presentations. Specific Jain passages and their historical contexts are considered principally through Stuart's published philological investigation; the underlying Prakrit witnesses have not all been independently collated here. The difference must remain visible in the argument. To give equal weight to all three cases does not mean pretending that every source has been examined to the same philological depth.

Two further bodies of scholarship make the comparison more difficult and more productive. Phyllis Granoff (1998a, 1998b, 2014, 2017) has examined Jain and Buddhist problems of karma, miraculous healing, and the concrete negotiation of care for sick mendicants, while scholarship on South Asian ritual and medicine has already shown that diverse explanatory frameworks coexist (Ferrari 2011; Wallace 2018; Gyatso 2015). Contemporary accounts of Jain mantra healing and of traditional healers in South India further demonstrate that authority is mediated by institutional structures, practices of communication, and the changing organization of access (Vekemans 2022; Nambiar and Mishra 2019). Donaldson and Bajželj (2021, chap. 4) furnish a particularly close additional predecessor on Jain medical ethics, and Ranganathan (2015) directly tests what "efficacy" may mean at Hindu healing shrines where symptom removal is not the defining outcome. These publications narrow any defensible originality claim still further. These studies are not treated as interchangeable examples of a timeless religious culture. They instead test how far a comparison drawn from historically different sources can responsibly travel.

The inquiry is textual and historiographical, with selective use of documented ethnographic research. It neither studies the clinical effectiveness of a medical procedure nor offers new fieldwork. It does not assume that categories developed within modern medicine, religious studies, or biomedical research map directly onto Sanskrit, Prakrit, and Pāli categories. Nevertheless, analytical differentiation is necessary: a source that defines a treatment, a rule that obliges nursing, and a hagiography that celebrates rescue make different kinds of claims. Their differences are integral to the religious significance of healing, not methodological inconveniences to be smoothed away.

Method: Care, Intervention, and Interpretations of Efficacy

Three distinctions organize the inquiry. First, **caregiving authority** concerns the obligation to assist and the competence required to do so. An attendant might have practical knowledge, appropriate motivations, and obligations defined by institutional relationships. These qualities do not require the attendant to claim that every treatment succeeds. Second, **therapeutic authorization** concerns the kinds of interventions recognized within a discourse: medicines, diet, recitation, offerings, mental discipline, or other practices. Authorization specifies what counts as an admissible means within an account; it may not identify the cause of every illness or prove effectiveness in individual cases. Third, **attributed efficacy** concerns the grounds on which a change, recovery, protection, or transformation is said to follow

from an intervention. Such grounds can be doctrinal, testimonial, narrative, procedural, or supported by forms of observation, and they should not be conflated.

One reason for separating these levels is that the English term 'healing' can refer to distinct outcomes. It may describe relief from pain, the resolution of disease, the restoration of ordinary activity, renewed social participation, the ability to continue religious discipline, or a transformation in the way suffering is understood. A text can value several of these simultaneously. Equally, it can represent the continuation of bodily illness without construing spiritual practice as a failure. Statements about the ultimate religious goal should not be substituted for empirical descriptions of a patient's clinical course, just as clinical recovery should not be represented as proof of religious liberation.

The methodological problem is also one of genre. Rules often arise from narrated incidents but establish prescriptions for future situations. Didactic medical compendia organize techniques according to particular theories of body, mind, and treatment. Hagiographies may celebrate extraordinary persons and support confidence in a teaching, yet they are not automatically medical records. Ethnographies examine situated actors, claims, experiences, and relationships within actual communities. A rigorous comparison cannot infer the same sort of evidence from each genre. Prescriptive inclusion of a treatment establishes authorization in that source; an ethnographic report of a practitioner's account establishes what someone reported or performed; neither alone warrants an independently verified efficacy claim.

A further difficulty is the relation between spiritual and bodily ends. In religious settings, a cure may be desirable without being final; an illness may be interpreted within an account of karma without rendering assistance impermissible; and a caregiving obligation may remain binding even where relief cannot be guaranteed. These possibilities challenge a two-part framework in which religion concerns meaning while medicine concerns cure. Such a framework misdescribes the Carakasamhitā, which places ritually directed treatments among therapeutic means, and it misses the Buddhist Vinaya's direct insistence on practical skill as a quality of a morally appropriate attendant. The issue is not to abolish all boundaries between medicine and religion, but to describe their local organization.

A comparison of obligations, methods, and efficacy should also ask whose statement has actually been verified. The relevant speaker may be a canonical legislator, the voice of an authoritative medical treatise, a hagiographic narrator, or a contemporary interview participant. That attribution determines what the historian can conclude. When a Vinaya rule instructs monastics to attend to the sick, the source supports a normative duty within its literary-institutional context. When a treatise describes a category of therapy, the source supports a recognized classificatory possibility. When a patient tells an ethnographer that a practice helped, the source supports an account of perceived benefit and its significance to that participant. These are neither equivalent claims nor points on a linear scale in which one is automatically more religious and another more rational. They answer distinct questions.

The analysis also imposes a limit on historical comparison. Jain monastic commentaries composed in particular periods, a canonical Buddhist disciplinary narrative, and an ancient Sanskrit medical treatise have

different chronologies, purposes, and social audiences. Their juxtaposition cannot establish a historical conversation unless evidence of transmission is separately supplied. The comparison is configured instead around a question posed to each source: what kind of authority is being articulated, and what kinds of evidence would be necessary to move from that authority to a claim about therapeutic outcome? This procedure facilitates comparison while preserving the limits of source-specific inference.

Jain Monastic Sources: From Ascetic Restraint to the Regulation of Care

Early Jain ascetic ideals assign great importance to restraint of bodily appetites, endurance, and attention to the karmic implications of action. A reader beginning from those ideals might suppose that caring for the body must always be suspect and that illness is primarily an occasion for endurance. Yet precisely this inference becomes difficult once the range and chronology of Jain sources are examined. Stuart's (2014) study shows that later Śvetāmbara monastic commentaries contain extensive discussions of ailments, physicians, therapies, medical instruments, and the complex situations faced by religious communities when a mendicant becomes sick. Her argument corrects any portrayal of Jain monastic medicine as an invariant rejection of treatment. That conclusion belongs to Stuart's work and must be credited as such.

What matters for the present comparison is the kind of problem that these commentaries formulate. The illness of a mendicant can generate claims from several directions. The ill person is committed to ascetic discipline; attendants may have obligations to assist; medical knowledge may come from specialists whose social status or proximity to the mendicant is itself regulated; and the community must consider how intervention can be integrated within the life it seeks to preserve. Thus the problem is not simply whether the patient desires comfort. It is also which conditions make assistance compatible with the regulation of religious conduct. The very appearance of extended instructions indicates that treatment has become a matter of institutional judgment.

Stuart draws particular attention to postcanonical Śvetāmbara discussions of medicine in the *Vyavahāra-bhāṣya* and *Bṛhatkalpa-bhāṣya*. Granoff (2017, 23–38) examines a particularly direct body of rules in the *Bṛhatkalpa* commentary complex, including extended discussions of how patients, attendants, and medical specialists negotiate the practical requirements of care. Her analysis foregrounds not only the supply of medicines or physicians but also the patient's conduct, the difficulties of satisfying the patient, and the effects of such difficulties on the community. It provides a much closer scholarly precedent for any claim concerning Jain monastic nursing than a general account of Jain attitudes toward illness. They do not function as timeless statements on behalf of every Jain school. They are specific commentarial witnesses to the negotiation of ascetic norms, requirements of care, and technical medical knowledge. In these sources the need to obtain medical assistance may interact with questions of movement, interpersonal contact, gendered separation, and the organization of monastic life. Stuart identifies cases in which responsibilities toward illness are sufficiently serious to qualify otherwise important restrictions. The force of the evidence lies in the

presence of argued exceptions and procedures, rather than in the claim that a new, medicine-friendly Jainism simply replaced an older ascetic religion.

This distinction is important. A rule modified for the sake of illness does not indicate that the prior rule was meaningless. On the contrary, the conflict is intelligible because both obligations retain significance. When a community carefully specifies when assistance may override an ordinary restriction, it recognizes competing duties within one discipline. The authorization of care is relational and conditional: the sick person's needs, the caregiver's standing, and the institutional consequences of the intervention matter together. One cannot derive from such regulations either that suffering always should be relieved or that the ascetic significance of endurance has disappeared.

The relation between medical knowledge and religious office is similarly complex. Stuart (2014) identifies references to physicians, medicines, and medical expertise, and discusses ways that medical competence can be valued within religious communities. Such evidence indicates that practical skill may affect an individual's usefulness or authority in cases of illness. But it does not establish that a monk who knows medicine possesses an unlimited license to experiment, that a religious superior's office independently guarantees a cure, or that monastic communities operated like modern hospitals. The question is more exact: how is assistance made legitimate within a discipline that cannot treat bodily well-being as an unrestricted end?

There is a further interpretive temptation: to explain this negotiation exclusively through karma. Karma is important to Jain accounts of embodied existence and distress, but its presence does not settle the practical obligations generated by illness. If illness is related to past action, a community may still specify acts of protection, comfort, and treatment. To move directly from a karmic explanation of suffering to a prohibition on caring for the sufferer would require explicit textual argument. Conversely, the existence of medicine does not entail that the community abandoned karmic explanations. The relevant distinction is between an account of why embodied suffering occurs and a rule about what persons should do in response.

Granoff's treatment of Jain healing narratives (1998a), read alongside Stuart, complicates the matter further. An extraordinary cure raises a doctrinal and narrative problem different from the one posed by an ordinary sick mendicant. Miraculous intervention may appear to challenge the expected unfolding of karmic consequences or the religious value attributed to endurance. A narrative can work through that tension by interpreting a cure as an exceptional religious act. A disciplinary rule about tending a sick fellow mendicant, however, neither needs a miracle nor makes recovery a condition of the caregiver's obligation. These genres therefore demonstrate two distinguishable forms of authorization: permission or duty to assist, and the authority ascribed to an exceptional healer. To discuss them under one heading of 'Jain healing' without further qualification would obscure their different questions.

A closer comparison with Donaldson and Bajželj (2021, chap. 4) reinforces the danger of overstating the novelty of this account. Their reconstruction of Jain views of medicine ranges from the early Śvetāmbara canon through later commentary, and explicitly examines the

emerging duty to care. Thus neither the identification of treatment exceptions nor the proposition that asceticism can coexist with assistance is an original finding of this article. What remains analytically useful is to specify that such an obligation does not, by itself, establish the legitimacy of every intervention or the truth of a narrated claim of cure. This is a comparative distinction developed across unlike genres, not a corrected chronology of Jain medicine. Moreover, the different textual strata require different historical predicates: a permission in a canonical passage, a detailed rule in a later commentarial witness, and a contemporary claim about healing must not be collapsed into one invariant doctrine.

The source-critical limit must be candid. The present article relies on Stuart's textual analyses for a significant part of the Jain commentarial evidence. It does not independently establish every Prakrit reading, the precise transmission of each commentary, or a continuous history from early ascetic codes to contemporary Jain healthcare. Its conclusion is more modest: in historically specific Jain institutional literature, the legitimacy of intervention can become a regulated matter of religious responsibility rather than a simple choice between renunciation and the pursuit of bodily comfort. Any more ambitious historical thesis would require a deeper edition-level corpus and specialist comparison than has been completed here.

Buddhist Vinaya: A Neglected Patient and the Competence to Nurse

The Pāli Vinaya, Mahāvagga VIII.26, gives a particularly vivid instance of a religious rule emerging from the condition of a sick person. In the narrated incident, the Buddha and Ānanda encounter a monk suffering from a severe bowel illness who has been left without effective assistance. The explanation given for his neglect is striking: the ill monk has not been useful to the other monks, so they do not attend to him. The Buddha and Ānanda help the monk and the subsequent discourse addresses the community's responsibilities. The narrative is not principally about the discovery of an effective drug. It exposes a failure of mutual obligation, in which the sick person's inability to contribute has become a reason for abandoning him (Mahāvagga VIII.26.1-4).

The instruction that follows makes the responsibility institutional rather than optional. It identifies relationships through which nursing should be provided—preceptor, teacher, pupil, and other monastic associates—and assigns responsibility to the *saṅgha* if the relevant individuals are unavailable. Failure to care carries an explicitly disciplinary consequence. The rule therefore corrects the logic of reciprocity implied by the monks' explanation. The patient should not become ineligible for assistance because illness has made him temporarily unable to provide service. The appropriate response is established as part of what membership in a disciplined community demands (Mahāvagga VIII.26.4).

The text then turns from obligations to the qualities of both patient and attendant. The patient is described as easier to nurse when able to cooperate with appropriate therapy, observe moderation, take medicine, report changes in symptoms truthfully, and endure painful experiences. These requirements can be misunderstood if read as shifting responsibility for illness onto a morally deficient patient. Their immediate setting is a practical description of the conditions of caregiving. The

list presupposes that the provision of help is not a magical transaction in which the sick person is merely passive. It names a relationship of communication, judgment, and bodily management that makes assistance more workable (Mahāvagga VIII.26.5-6).

The corresponding list of an adequate attendant is even more revealing. The caregiver must know how to prepare medicine, distinguish beneficial from unsuitable treatment, be motivated by goodwill rather than material reward, perform unpleasant physical tasks without revulsion, and offer appropriate religious instruction. These capacities span what a modern reader might separate into medical, ethical, affective, and doctrinal domains. Their coexistence is not evidence that all these capacities are identical. It is evidence that the source's model of qualified nursing cannot be exhausted either by technical preparation of medicines or by warm concern in the absence of competence (Mahāvagga VIII.26.7-8).

This is a decisive source-level difference between recognizing that an illness exists and being authorized to care for it properly. Religious membership may generate an obligation to assist; satisfactory performance of that obligation nevertheless requires several forms of competence. The rule does not suggest that sincere goodwill alone is an adequate medical procedure. Nor does technical skill authorize care motivated entirely by material gain. In the Vinaya's setting, legitimate intervention is a composite practice: the caregiver's motivations, bodily actions, medical competence, and religious guidance all matter. This is not a modern holistic therapy model projected backward; it is an observation about the distinct conditions explicitly named by the text.

The narrative also resists a false contrast between medicine and liberation. Encouraging a sick monk through teaching does not replace medicine, and preparing medicine does not discharge every responsibility to the person. The institution cares for someone who remains a religious practitioner even while subject to bodily distress. What is healed or improved is therefore not fixed by a single description. Medicine may address the bodily condition; supportive speech may sustain a person's participation in the religious life; practical cleaning and feeding may prevent abandonment and indignity. The passage does not claim that these interventions are interchangeable or uniformly successful.

It would be equally wrong to treat the passage as an empirical record of how faithfully all historical Buddhist monasteries treated sick members. A rule can identify conduct whose neglect its authors considered possible or significant, not demonstrate universal compliance. Moreover, it cannot stand as the entire Buddhist history of illness. Wallace (2018) surveys a much broader field of Buddhist medical knowledge and practice, and other Buddhist communities developed their own traditions of treatment and care. The evidentiary strength of Mahāvagga VIII.26 lies in the explicit formulation of institutional responsibility and the qualifications necessary for caregiving. It does not lie in representing all Buddhist therapeutic doctrines.

A tension remains between the force of the norm and the incomplete control a caregiver has over outcome. The Vinaya imposes responsibility without guaranteeing recovery. The monk in the narrative receives assistance, but the regulatory conclusion is framed around appropriate care rather than a demonstration that

treatment abolished his condition. This permits an important distinction: an institution can fail morally by neglecting a patient even when no cure was guaranteed, and a caregiver can fulfill a serious duty while the course of illness remains uncertain. That distinction is a stronger basis for comparing religious healing than attributing a characteristic compassion or therapeutic power to Buddhism as a whole.

Carakasamhitā: Therapeutic Classification without a Religious-Medical Binary

The *Carakasamhitā*, Sūtrasthāna 11.54, organizes therapeutic means in a triad: *daivavyapāśraya*, *yuktivyapāśraya*, and *sattvāvajaya*. Its wording is particularly consequential for an inquiry into healing authority because the three terms belong to a medical discourse that nonetheless encompasses activities later analysts might separate into spiritual, material, and psychological interventions. The first includes mantras, auspicious rites, offerings, observances, expiations, fasting, and related acts. The second concerns the rational arrangement of diet and medicinal substances. The third involves restraint or regulation of the mind in relation to harmful objects (*ahita*). The accessible Sanskrit presentation and translation corroborate the threefold division and its immediately stated examples (*Carakasamhitā*, Sūtrasthāna 11.54).

The wording of the Sanskrit list further cautions against a rigid division. Alongside mantras and offerings, the enumeration of *daivavyapāśraya* includes *auśadhi*, often understood here among the auspicious or ritually directed supports, while *yuktivyapāśraya* is defined through the deliberate arrangement of *āhāra* and *auśadha* substances. The overlap of vocabulary is important: the classification is not an assertion that a medicine ceases to be medicinal when used within a ritually structured approach. Nor does the verse spell out a modern method of testing an intervention's causal effect. To interpret it as an early equivalent of a clinical trial or as a ranking of religions against science would import priorities and distinctions that the passage does not state. The better question is which kinds of reasoning, material practice, and religious authorization are gathered under the terms of the medical system, and what additional evidence would be needed to establish its therapeutic practice in a particular historical setting.

The passage does not say that one treatment is 'religious' because ineffective and another 'medical' because effective. Nor does it reduce mental discipline to a modern psychotherapy whose concepts and institutional setting are unchanged across two millennia. The term *yukti* signals a mode of reasoning and arrangement within the medical system, not a blanket identification with contemporary evidence-based medicine. Likewise, *daiva* in the compound should not be converted without qualification into a simple category of supernatural intervention detached from medical thought. The relevant point is textual: what contemporary readers frequently separate into opposed domains appears within one therapeutic classification.

This is not the same type of authority as the Vinaya's nursing requirements. The Buddhist passage addresses what a monastic community owes to a sick member and what qualifies an attendant to act. The Caraka passage distinguishes recognized modes of treatment within a medical discourse. It does not by itself identify an institutional duty toward a particular patient, nor does it tell us that any of the listed ritual actions succeeded in a

given illness. By treating the two as sources that make different claims, we can place them in comparison without creating a fictitious uniform religious medicine. One organizes professional or therapeutic possibility; the other regulates caregiving conduct.

The classification has implications for how the patient is imagined. If therapies can be specified through physical substances, religious observances, and the regulation of mental attention, the patient cannot be understood solely as a site on which an external substance acts. But caution is necessary. The passage is too compact to support an entire theory of patient agency, and the larger medical treatise would have to be examined to determine the allocation of decision-making among patient, physician, and other participants. The safer conclusion is that the listed modes of treatment presume more than one kind of intervention. Their presence in a shared classification does not settle the practical hierarchy among them in specific clinical circumstances.

Nor should the inclusion of ritual within a medical compendium be taken as a guarantee of efficacy. The passage records authorization at the level of classification. One would need disease-specific discussions, clinical reports where available, and appropriate historical controls to assess what a practitioner claimed a ritual, diet, or medicine could accomplish. Even a historically documented claim of success would not alone demonstrate causal efficacy by contemporary clinical standards. To distinguish classification from proof is not to dismiss the medical text. It is to respect the difference between the epistemic work done by a medical taxonomy and that of empirical outcome evidence.

The Hindu label assigned to this case also requires careful use. The *Carakasamhitā* is a classical Sanskrit medical composition rooted in a particular intellectual and cultural history. Its inclusion of offerings and observances does not imply that every Hindu temple, household, or ritual specialist endorsed this precise therapeutic taxonomy. Neither is a medical compendium equivalent to a Hindu sectarian doctrinal treatise. The word 'Hindu' identifies one historically connected source setting in a broader comparative project; it cannot erase the substantial difference between Āyurvedic medical knowledge and an individual devotional or ritual healing tradition.

A further reason not to impose the binary between religion and medicine is historical. Scholarship on South Asian healing has long shown interactions among medical practice, ritual procedures, divine agencies, and institutional identities (Ferrari 2011). The Caraka passage supports that observation at the textual level, but a claim of originality would need to demonstrate a new interpretive consequence. Here its value is more specific. It shows how the authority of a therapeutic procedure may be supplied by its location within a recognized classification, while leaving open the separate questions of professional competence, individual suitability, and demonstrated outcome. The distinction provides a controlled counterpoint to the Vinaya's caregiving rules and to the Jain problem of authorizing intervention within ascetic regulation.

Miraculous Cures: The Narrative Attribution of Efficacy

A third kind of evidence becomes prominent when texts narrate extraordinary healing. Granoff's paired studies

(1998a, 1998b) are indispensable because they examine precisely the relationship between karma, suffering, miracle, and religious claims to therapeutic power. In her study of Buddhist avadāna literature, the Buddha's capacity to heal may be narrated as a distinctive manifestation of his religious accomplishment, sometimes extending to the efficacy of his teaching or a truth-act. These stories are not reducible to descriptions of medicines administered in ordinary circumstances. They use a cure to make the status and reach of religious power intelligible within a narrative world (Granoff 1998b).

The question of karma makes such stories especially challenging. If an affliction is understood within a theory of karmic consequences, its removal through an extraordinary intervention may raise an apparent tension. Does the cure interrupt an otherwise warranted consequence? Does it reveal a kind of power that exceeds the usual framework? Or is the illness interpreted in a way that permits extraordinary help without denying causality? The precise answers vary among texts and historical settings; Granoff reconstructs these problems rather than claiming that every Buddhist story advances the same doctrine. The general observation that karma and miraculous healing can coexist, or come into tension, is therefore not original to the present article.

For comparative purposes the stories illustrate a different mechanism of authorization. Where a monastic rule identifies who must care, and a medical treatise describes what qualifies as treatment, a miracle narrative can identify why an extraordinary religious figure should be recognized as possessing healing power. Such recognition may be sustained through narration, transmission, and communal interpretation. The implied success of a cure serves the story's religious argument. But we must distinguish a **narrated cure** from a **historically observed outcome** and from a **clinically demonstrated effect**. Each might be worth investigating; they are not three labels for the same evidentiary status.

This distinction protects comparative work from two symmetrical errors. One error is to treat the assertion of a miracle as historical proof of the event. The other is to presume that a narrative is of no scholarly interest unless modern clinical methods validate the cure. A religious narrative can matter because it organizes trust, authority, doctrine, and remembered exemplarity. The historian can analyze those functions without issuing a medical endorsement. The analysis becomes more precise when it asks why a certain outcome is narrated as belonging to one agent or teaching rather than another, and what authority that attribution helps to produce.

The difference from institutional care is consequential. A sick mendicant may be entitled to help even without a promising prospect of cure; an extraordinary healer in a story may be celebrated because cure is represented as certain or decisive. The first formulation allocates obligation under uncertainty, while the second narratively resolves uncertainty by displaying power. The contrast is not a division between rational and irrational religion. It is a distinction between texts governing ordinary conduct and texts establishing the exemplary efficacy of a person or teaching. Both can belong to one religious tradition at different times or in different genres.

Documented Contemporary Practice: Authority in Circulation

Research on contemporary healing adds an evidentiary layer that the ancient and medieval texts cannot supply. Vekemans (2022) examines Bhaktamar Mantra Healing, a practice drawing on the Jain *Bhaktāmar Stotra* and combining devotional and tantric elements in a relatively recent and publicly mediated form. The study describes how digital media help circulate teachings, representations of therapeutic benefits, and accounts of their mechanics. It identifies a changing context in which healing is organized for participants beyond a single monastic or temple community. The significance of the case is not that 'Jainism has always believed in mantra cures'; it is that claims to religious efficacy can be reshaped through contemporary modes of communication and access.

The ethnographic and media evidence permits several different sorts of statement. It supports a claim that practitioners present, circulate, and organize a healing system grounded in religious materials. It permits an analysis of how authority can be expressed through instructional systems, expert identities, and publicly available accounts of results. It does not, on its own, establish that any particular illness was cured by a mantra, or that participants interpret the system identically. To reproduce advertised health benefits as clinical conclusions would confuse a study of therapeutic authority with an independent evaluation of efficacy. Vekemans's own analysis emphasizes the blend of religious, spiritual, and scientific narratives in the practice's public presentation.

A related issue appears in research on local healers in South India. An ethnographic investigation of fifty-one healers and their relationships with other stakeholders describes power emerging not only from state recognition but also from respected persons, healer collectives, ritual procedures, and accounts of sacred vocation (Nambiar and Mishra 2019). Such findings show why therapeutic authority cannot be reduced to the possession of a single professional credential. They also underscore that the contemporary politics of treatment are embedded in institutions and public systems of legitimacy. This is not direct evidence for a Hindu, Jain, or Buddhist canonical prescription; the population of healers and their contemporary setting require independent identification and interpretation.

The contemporary material changes the scale of the comparison. The Caraka text authorizes categories of therapeutic means; a living healing enterprise publicizes and performs specific practices for actual audiences. Their evidentiary relationship is not one of timeless continuity. A medical passage that includes mantras is not sufficient proof that a twenty-first-century therapeutic movement inherited its particular techniques from that passage. A historically responsible comparison must trace intermediaries if it wishes to establish lineage. Without such a chain, the two sources may be compared only as contrasting ways claims to treatment and authority are organized.

Ranganathan's study of Mahānubhāva healing shrines provides a particularly direct challenge to an argument that merely says religious healing cannot be measured by symptom removal (Ranganathan 2015). In the documented cases, sufferers may understand the intensification of distress as part of a therapeutic trajectory, recognize the return of symptoms without

abandoning the shrine, and develop durable relationships with a community. The study therefore demonstrates from ethnographic evidence that expected completeness of recovery, interpretations of suffering, and community refuge can differ from a biomedical model of cure. A05 cannot claim to discover these possibilities. Nor can the shrine research be read as evidence that symptom intensification is a medically desirable intervention. Its importance for the present inquiry is more discriminating: when the outcome sought or reported by participants is not clinical remission, an investigator must not answer a question about their religious experience by substituting a different endpoint; neither may the investigator infer that the endpoint they name proves biomedical effectiveness.

A further complication concerns patient experience. Ethnography can record testimony about relief, hope, belonging, changes in emotional state, or disappointment. These reports can be important outcomes for the history and anthropology of healing even when they are not equivalent to a laboratory measure of disease remission. That does not mean testimonial experience is irrelevant or that biomedical outcomes are the only valuable effects. It means different questions demand different evidence. A report of feeling supported may be meaningful evidence of perceived support; it cannot silently be converted into evidence that an infection was cured. Conversely, a record of clinical improvement does not by itself explain how a patient interpreted the experience in religious terms.

For A05, contemporary work is therefore a methodological control, not a free-standing proof of a comprehensive South Asian theory. It demonstrates that the authority to name, offer, and interpret healing can move through new organizations and media. It also reveals why anyone attempting to draw broad conclusions about therapeutic outcomes must distinguish advertised claims, participant accounts, practitioner judgments, and independently assessed results. The ancient textual corpus makes some of these distinctions conceptually visible; contemporary evidence allows the actual social production of claims to be studied in particular contexts.

Comparative Analysis: Three Questions of Therapeutic Authority

The comparison can now be stated more exactly. The selected Jain commentarial literature addresses the circumstances under which religious discipline permits or requires assistance to a sick mendicant. The Vinaya provides an unusually direct prescription of communal duty and specifies practical and ethical qualities of competent nursing. The *Carakasamhitā* differentiates therapeutic approaches, including interventions that a modern classification might call ritual, medical, or psychological. Healing narratives, as studied by Granoff, organize exemplary claims to power through descriptions of cures. These are comparable not because they describe one unchanged act of healing, but because each articulates a different relationship between suffering and authorization.

The first question is jurisdiction: who must act, who may act, and under whose responsibility a suffering person falls. The Buddhist case answers this question by allocating an obligation to preceptors, associates, and ultimately the monastic community. The Jain discussions examined by Stuart reveal regulatory

negotiations through which assistance becomes permissible or important despite other ascetic restrictions. Neither case authorizes an indiscriminate claim that all illness is a communal responsibility in exactly the same sense. Their contexts, histories, and normative formulations differ. Still, both indicate that a tradition concerned with liberation can make care a serious institutional matter.

The second question is admissible method: what sorts of procedures may be undertaken, and what qualifies their use. The Vinaya's competent attendant knows how to prepare medicine and distinguish helpful from unsuitable interventions. Caraka offers a classification that explicitly includes diet, medicines, ritual practices, and mental restraint. These claims overlap insofar as they refuse to identify religiously significant care with compassion alone. But the similarities have limits: preparing medicine is a qualification of a specific caregiver in one source, while naming a category of treatment is a general theoretical operation in another. These must not be compressed into one shared philosophy of therapeutic pluralism.

The third question is attribution of efficacy: who or what is credited when an intervention is said to work. Granoff's hagiographic materials permit the study of cures as claims about exemplary religious agents or teachings. Modern practices studied by Vekemans circulate explanations and reported outcomes through particular media and institutions. By contrast, the Vinaya's requirement to nurse a sick monk does not depend on demonstration of miraculous success. Once these functions are separated, it becomes possible to ask what a source would count as failure: leaving the sick without care, employing an unsuitable method, or failing to substantiate a claim of cure are different failures.

One way to test the distinction is to ask what would count as the *failure* of each claim, rather than merely asking whether every case involves healing. If monks neglect a patient because he cannot repay assistance, the normative failure in the Vinaya is discernible even before any attempt to cure him. If a caregiver is well intentioned but cannot recognize which measures are appropriate, another failure—lack of competence—can be identified by the same rule. In a medical classification, by contrast, a text's listing of several modes of treatment does not certify each application; evaluating an application would require evidence of diagnosis, procedure, and outcome not supplied by the list itself. And when a narrative credits a healer with a cure, the historian can analyze the narrative's criteria of authority while withholding assent to its clinical causation. This asymmetry makes a consequential interpretive difference: an obligation may remain binding after a failed treatment, while a cure claim cannot be established by the duty to try.

The three-dimensional distinction has another limit. It does not follow that every source expressly separates the kinds of authority it evokes. The Vinaya joins practical preparation, ethical disposition, and religious instruction in one description of a good attendant; *Carakasamhitā* treats religiously inflected means as a legitimate part of the therapeutic repertoire. The analytical separation is therefore the historian's test of inference, not an ancient institutional constitution. Its value can be judged by whether it prevents a specific mistake: deriving proof of efficacy from permission, deriving unlimited treatment

authority from compassionate responsibility, or inferring the absence of care from the persistence of suffering.

The central result is not a tidy three-tradition typology. Jain writers also narrate cures; Buddhist traditions also classify medical substances and treatment; Sanskrit medical traditions also recognize professional competence and moral obligations. The three selected textual settings are not exclusive portraits of their respective traditions. A04 already examined the regulation of the body as an instrument of disciplined practice; A05's object is distinct because it asks how persons and institutions respond to another person's illness, authorize interventions, and interpret therapeutic results. This preserves the division between ascetic transformation and the authority to heal without denying their occasional intersection.

A difficult counterexample illustrates the importance of separating the questions. Suppose an attendant competently prepares and administers an intervention that does not restore the patient's health. The moral standing of the caregiver cannot be read automatically from the outcome. The Vinaya would still require attention to the competence, motivation, and obligations governing assistance. Conversely, if a patient recovers after a ritual procedure, the temporal sequence alone does not establish that the ritual caused the recovery, although participants may experience or narrate the event as religiously significant. A historical interpreter must make the basis of each inference explicit. The rule for a nurse, the report of a cure, and the causal explanation of a recovery belong to different analytical levels.

Another test concerns the meaning of suffering. A tradition can interpret illness through karma while still requiring care; it can value endurance without converting every disease into a desirable condition; it can describe a medical method without guaranteeing freedom from pain. The opposition between treating suffering as spiritually productive and treating it as physically harmful is consequently too simple. The relation depends on whether the source is discussing an ascetic's self-discipline, a community's responsibilities, a physician's choices, or a narrator's presentation of exemplary power. A05 should not make the mere coexistence of those possibilities its originality claim. Its modest analytical contribution is to specify which kinds of authority and evidence are being confused when they are treated as one phenomenon.

Scholarly Contribution and Objections

The most substantial objection to this article is that its argument may amount to a careful arrangement of established findings, with neither a newly edited text nor new ethnographic evidence. Stuart (2014) and Granoff (2014, 2017) already demonstrate the complexity of medicine, patient behavior, and caregiving responsibility in Jain monastic commentary; Wallace (2018) establishes the richness of Buddhist medical evidence; Granoff (1998a, 1998b) analyzes the relationship between karma and extraordinary healing; and Ferrari's edited collection (2011) investigates ritual practices, disease, and the interpretation of health across South Asian settings. Gyatso (2015) gives a more historically ambitious account of the relationship between medical learning and Buddhist religious categories in Tibet. Donaldson and Bajželj (2021) already reconstruct a Jain duty to care and medical exceptions, while Ranganathan (2015) directly problematizes clinical cure as the sole

endpoint of shrine healing. These works prevent A05 from claiming to have discovered that 'religion and medicine' are not separate, or that medical care and ascetic religious life can coexist.

The proposed contribution is accordingly smaller than a new history of Indic healing, a demonstration of novel ritual efficacy, or the recovery of a previously unrecognized duty to treat. It is an argument about **comparative warrant**: different sources are often grouped together because they concern sickness, although one prescribes care, another classifies treatment, and a third attributes a cure to extraordinary power. Those activities require different standards of evidence. This interpretive distinction can improve comparisons by identifying the exact proposition supported by a source and by distinguishing authority to act from authority to claim success. Its utility is strongest where an unqualified use of 'healing' would otherwise turn religiously important action into an unsupported claim of therapeutic efficacy.

A second objection is that this framework risks importing modern distinctions into earlier materials. It does. 'Jurisdiction,' 'authorization,' and 'attribution' are analytical terms used to organize comparison; they are not proposed as equivalents for ancient technical vocabulary. Their value depends on whether they clarify rather than displace the terms and relationships articulated by the sources. The framework would fail if it transformed *sattvāvajaya* into an unqualified synonym for psychotherapy, read *daivavyapāśraya* as irrational treatment, or treated the Vinaya's *gilānupaṭṭhāka* as simply a modern professional nurse. Each term must remain tied to its historical textual setting.

A third objection concerns the unevenness of the source base. Direct examination of the Sanskrit and Pāli passages is stronger than the present independent verification of Jain commentarial textual witnesses. This limits what can be claimed about exact Jain readings and their textual history. It also limits any account of chronological change that moves from early Jain canonical restraint to later medical flexibility. A journal-ready paper would benefit from checking the original editions behind Stuart's translations and interpretations, comparing relevant Jain commentarial variants, and testing whether alternative readings materially affect the comparative argument. Those checks should be documented rather than presumed complete.

Finally, the paper does not provide evidence of clinical efficacy for the healing procedures it discusses. This is a limitation by design, but not a reason to dismiss either ritual practices or the experiences of patients. It is possible to take religious actors' claims seriously as claims about authority, meaning, or experience while refraining from turning them into unverified recommendations or medical facts. A historically and ethically responsible account of healing needs both intellectual hospitality to its subjects and clarity about what it has established. The distinction is especially important when contemporary health claims are circulated to vulnerable audiences.

Conclusion

The religious significance of illness is not exhausted by theories of why suffering occurs, and the authority to respond to illness is not identical with the power to guarantee a cure. In the selected Jain monastic literature, the authorization of care is negotiated within ascetic

regulations and the institutional demands of illness. In Mahāvagga VIII.26, the neglected monk generates an explicit communal duty, and the text combines medicine, practical service, goodwill, and teaching in its account of qualified care. In the Carakasamhitā, a medical taxonomy recognizes multiple modes of therapeutic intervention without making the modern opposition between religious and practical treatment foundational. Healing narratives and documented contemporary practices introduce further questions about whose power is credited and how accounts of success circulate.

The comparative finding is therefore a methodological and interpretive one. Obligations to care, classifications of appropriate means, and claims about therapeutic efficacy should be reconstructed separately before their interactions are analyzed. Shared concern for suffering does not establish identical theories of its origin, identical standards for intervention, or identical outcomes. Likewise, the inclusion of ritual among authorized practices does not itself demonstrate the result of an individual treatment. These distinctions retain the ethical force of caregiving while recognizing the diverse ways religious communities and medical texts interpret illness.

The article does not propose a new universal theory of healing in Jainism, Buddhism, and Hinduism. Its secure result lies in identifying the different normative and evidentiary operations made visible by a small, historically uneven, but carefully specified corpus. Whether that comparative clarification constitutes a sufficiently independent scholarly intervention remains conditional on fuller comparison with specialist literature, especially work on Jain medical ethics and shrine efficacy, and further edition-level checking of the Jain sources. Those limits do not erase the interpretive result; they define what the present evidence can legitimately sustain.

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