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MEDICINAL PLANTS IN EARLY BUDDHIST INDIA: AN ANALYTICAL STUDY

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ABSTRACT

This article examines medicinal plants and other plant-derived substances in early Buddhist monastic life, with particular reference to the Bhesajjakhandhaka (Section on Medicines) in Mahāvagga VI of the Pāli Vinaya Piṭaka. It asks which substances were permitted, how they were classified and prepared, under what disciplinary conditions they could be used and stored, and how far the Vinaya material can be compared with classical Āyurveda. The study employs qualitative textual, historical-contextual, and comparative analysis, using the English translations of Horner and Rhys Davids and Oldenberg together with scholarship on Buddhist medicine, the history of Indian medicine, medicinal plants, and Buddhist environmental thought. The evidence reveals a rule-based monastic materia medica that distinguishes the five medicinal foods ghee, fresh butter, oil, honey, and molasses from further classes of medicinal substances such as roots, astringent decoctions or extracts, leaves, fruits, gums or resins, and salts. The Vinaya regulates permission, preparation, timing, storage, and use, but does not present a systematic medical theory comparable to the classical Āyurvedic compendia. Structural parallels with Āyurveda indicate participation in a broader medical culture, but they do not by themselves establish direct borrowing or chronological priority. Modern botanical identifications should likewise remain provisional because correlations among Pāli plant names, Sanskrit equivalents, vernacular terminology, and Linnaean species are often uncertain. Early Buddhist monastic medicine is therefore best understood as a form

of disciplined health care embedded within the institutional and ethical life of the renunciant community.

KEYWORDS: Early Buddhism; medicinal plants; Vinaya Piṭaka; Bhesajjakkhanda; Buddhist medicine; Āyurveda.

INTRODUCTION

Illness was a concrete reality of early Buddhist renunciant life. Monks and nuns who had left household life could no longer depend upon domestic arrangements for food, nursing, and medicines. The Vinaya therefore addresses health care in practical and disciplinary terms. It records episodes involving sick monastics, specifies substances and equipment that may be used, regulates preparation and storage, and limits practices that could lead to accumulation or misuse. Mahāvagga VI, conventionally known as the Bhesajjakkhanda, is the principal source for the present study.

The central textual basis is Mahāvagga VI as translated by Horner (1951, pp. 269–350), with the opening catalogue compared with Rhys Davids and Oldenberg (1882, pp. 42–48). The section begins with monks suffering from a seasonal illness and introduces five medicinal foods: ghee (sappi), fresh butter (navanīta), oil (tela), honey (madhu), and molasses (phāṇita). It subsequently treats animal fats and classes of plant-derived medicines, including roots, astringent decoctions or extracts, leaves, fruits, gums or resins, and salts. The governing principle is conditional permission: substances may acquire a medicinal status when required by illness and when their use remains within Vinaya restrictions.

This article argues that the Vinaya material should not be treated merely as a list of remedies. It constitutes a prescriptive framework governing the acquisition, preparation, storage, administration, and permissible use of medicinal substances. The study asks: Which substances are named? How are they classified? What do the rules reveal about monastic care? In what respects can the material be compared with Āyurveda? How certain are modern botanical identifications? Finally, what, if anything, may responsibly be inferred about environmental values? The study does not evaluate clinical efficacy; its purpose is textual, historical, and methodological.

1. Review of Literature

The hierarchy of evidence begins with the Pāli Vinaya itself and its major English translations. Horner (1951) provides the principal translation used here, while Rhys Davids and Oldenberg (1882) supply an independent rendering for comparison. Their broad

agreement on the sequence of medicinal foods, roots, extracts, leaves, fruits, gums, and salts strengthens the descriptive basis of the study, although differences in translation also caution against treating English equivalents as exact technical identities.

Zysk (1991) places Buddhist monastic medicine within the history of Indian medicine and analyses the same *materia medica* categories, emphasizing the boundary between food and drug and noting structural correspondences with early Āyurvedic materials (pp. 73–83). Sharma (1992, pp. 117–119) likewise treats the Tripiṭaka as an important source for Indian medical history and summarizes the five medicines and the principal classes of vegetable substances. Salguero (2017), including Fiordalis's treatment of the Pāli Section on Medicines, broadens the comparative study of Buddhist medicine and draws attention to the regulation of edible medicines, storage, distribution, containers, and monastic reputation.

Meulenbeld (1999–2002), Dominik Wujastyk (2003), and Dagmar Wujastyk (2012) provide historical and textual controls for comparison with classical Āyurveda. Their work is especially important because the *Caraka Saṃhitā*, *Suśruta Saṃhitā*, and later medical literature represent complex textual histories; similarities cannot automatically establish the direction of borrowing. Botanical and *materia medica* references such as Sivarajan and Balachandran (1994), Warriar et al. (1993–1996), Chopra et al. (1956), and Kirtikar and Basu (1935) are useful for cross-identification, but their taxonomies and synonyms must be handled with caution.

Dhammika (2018) compiles Pāli flora and explicitly warns that many identifications of ancient plant names are conjectural or disputed. Wijayaratna (1990) and Chakravarti (1987) are more useful for monastic and social context than for botanical identification. Sahni (2007) and the Dalai Lama XIV (2007) address environmental responsibility from modern perspectives. Sahni's methodological warning is particularly relevant: contemporary environmental ethics should not be projected uncritically onto early Buddhist texts.

The principal research gap lies in integrating catalogue and context. Existing studies identify medicines or situate Buddhist medicine within Indian medical history, but a focused analysis must correlate substances with their disciplinary conditions, distinguish canonical statements from later therapeutic interpretations, and express botanical identifications in graded rather than absolute terms.

2. Research Methodology

This article employs qualitative textual analysis, historical-contextual analysis, and comparative analysis. The primary method is a close reading of Mahāvagga VI in Horner

(1951), checked against Rhys Davids and Oldenberg (1882). The unit of analysis is not simply an individual plant name but the regulatory episode in which illness or need gives rise to a permission, together with the class of substance, its preparation, mode and timing of use, storage, and associated material practices.

The sources are used according to an explicit hierarchy. Direct Vinaya evidence has priority. Historical studies by Zysk, Sharma, and Salguero interpret the canonical material but do not replace it. Āyurvedic and botanical literature is used comparatively and does not establish the absolute identity of a Pāli plant term. Modern environmental literature is confined to a concluding reflection rather than treated as evidence for ancient ecological doctrine.

Plant identification is assessed through four considerations: lexical similarity between Pāli terms and Sanskrit or vernacular forms; the plant part or preparation named; geographical plausibility; and convergence among reference traditions. These criteria rarely produce absolute certainty. Accordingly, the analytical table uses graded labels such as “probable,” “uncertain,” and “disputed.” A probable identification indicates a defensible modern correspondence, not certainty regarding every historical specimen, regional usage, or preparation.

Three limitations follow. First, the Vinaya is a transmitted normative text rather than a clinical casebook. Second, its present redaction should not be equated uncritically with a single historical date. Third, later Āyurvedic, ethnobotanical, or modern therapeutic claims must not be retrojected into the early rule. Dhammika’s plant identifications are useful for locating possible correspondences, but later medicinal uses cited in modern botanical literature are not treated here as claims made by the Vinaya.

3. Medicinal Herbs and Herbal Products in the Vinaya

3.1 Healing as a Part of Monastic Life

The narratives of the Bhesajjakkhanda make healing an integral part of monastic life. Monks suffering from an autumnal illness are described with symptoms such as vomiting, wasting, abnormal complexion, and prominent veins. In response, five substances—ghee, fresh butter, oil, honey, and molasses—are permitted because they can serve a medicinal function even though they are also nourishing substances. The rules therefore negotiate a boundary between food and medicine rather than assuming that the two categories are always fixed.

The medicinal status of a substance is relational and regulatory. A nourishing substance may be permitted under conditions of illness, while its timing and storage remain subject to

discipline. Zysk's description of these items as medicinal foods is useful because it captures their intermediate position between nourishment and drug. The *Vinaya* itself, however, primarily records the problem and the permission; later commentators and historians supply fuller medical explanations.

3.2 Classification, Parts, and Form

Beyond the five medicinal foods and certain animal fats, plant-derived substances are classified chiefly by plant part or processed form rather than by disease. The root category includes such items as turmeric, ginger, sweet flag or orris root, *ativasā*, black hellebore, *uśīra*, and *baddhamuttaka*. The mention of large and small grinding stones indicates that permission extended not only to medicinal substances but also to equipment required for their preparation (Horner, 1951, pp. 271–272; Rhys Davids & Oldenberg, 1882, pp. 44–45).

The next category is *kasāya*. Horner translates this as “astringent decoctions,” while Zysk prefers “extracts,” a difference that is analytically important because the term may indicate both astringency and a processed preparation. Named sources include *nimba*, *kuṭaja*, *pakkava*, and *nattamāla*. Leaves are separately permitted, including *nimba*, *kuṭaja*, *paṭola*, *tulasi/sulasī*, and *kappāsika*. Fruits include *vilaṅga*, long pepper, black pepper, the three myrobalans—*harītaka*, *vibhītaka*, and *āmalaka*—and *gotṭhaphala*. Gums or resins include forms of *hiṅgu* and other resinous substances, followed by five kinds of salt (Horner, 1951, pp. 272–273; Rhys Davids & Oldenberg, 1882, pp. 45–48).

This arrangement has analytical significance. Some categories refer to plant anatomy—roots, leaves, and fruits—whereas others refer to transformed substances such as extracts and resins. It is therefore inappropriate to impose a modern botanical taxonomy or disease-based formulary upon the text. The *Vinaya* presents a practical monastic classification concerned with what may be obtained, processed, stored, and used.

3.3 Preparing, Storing, and Administering Medicines

The medicinal rules imply a modest but significant material infrastructure. Roots require grinding stones; ointments require containers and applicators; nasal medicines require instruments; and decoctions require processing. The *Vinaya* therefore regulates not only substances but also the tools and containers through which medicines are prepared, stored, and administered. Salguero (2017, pp. 118–119) emphasizes that storage and distribution are also matters of monastic discipline because the accumulation of edible substances could affect the public reputation of mendicants committed to non-possession.

Storage rules express calibrated restraint. The five basic medicinal foods are subject to stricter temporal limits, whereas other medicinal categories may be stored under conditions of

genuine need. The distinction is understandable because substances closest to desirable foods create a greater risk of accumulation or ordinary consumption. The underlying concern is not merely spoilage or nutrition but the regulation of reasonable possession within a renunciant community.

3.4 Analytical Table

Table 1 distinguishes what the Vinaya explicitly permits from proposed modern botanical identifications. “Stated Vinaya use” refers to the regulatory function expressed in the text, not to later assumptions about the treatment of particular diseases.

Table 1. Selected medicinal plants and plant-derived substances in Mahāvagga VI.

Pāli Term	Translation / Category	Part / Preparation	Stated Vinaya Use	Proposed Botanical Identification	Checked Source	Certainty
Haliddā	turmeric; root medicine	rhizome/root; ground as needed	permitted for illness when not functioning as ordinary food	Curcuma longa	Horner, 1951, p. 271; Dhammika, 2018, p. 202	Probable
siṅgivera	ginger; root medicine	rhizome/root	same root-medicine rule	Zingiber officinale	Horner, 1951, p. 271; Dhammika, 2018, p. 183	Probable
Nimba	neem; kasāya and leaf medicine	astringent extract/decoction; leaves	permitted as an extract and as leaves when medically needed	Azadirachta indica	Horner, 1951, p. 272; Dhammika, 2018, p. 120	Probable
kuṭaja	kuṭaja; kasāya and leaf medicine	extract/decoction; leaves	permitted as an extract and as leaves	Holarrhena pubescens	Horner, 1951, p. 272; Dhammika, 2018, p. 79	Probable
sulasī/tulasi	holy basil; leaf medicine	Leaves	permitted within the leaf	Ocimum tenuiflorum	Horner, 1951, p. 272;	Probable

			category		Dhammi ka, 2018, p. 111	
pippalī/pipp ala	long pepper; fruit medicine	fruiting spike/fruit	permitted within the fruit category	Piper longum	Horner, 1951, pp. 272–273; Dhammi ka, 2018, p. 129	Probabl e
Marica	black pepper; fruit medicine	Fruit	permitted within the fruit category	Piper nigrum	Horner, 1951, pp. 272–273; Dhammi ka, 2018, p. 149	Probabl e
āmalaka	emblic myrobalan; fruit medicine	fruit	permitted within the fruit category	Phyllanthus emblica	Horner, 1951, p. 273; Dhammi ka, 2018, p. 52	Probabl e
Harītaka	chebulic/yell ow myrobalan; fruit medicine	Fruit	permitted within the fruit category	Terminalia chebula	Horner, 1951, p. 273; Dhammi ka, 2018, p. 201	Probabl e
vibhītaka	belleric myrobalan; fruit medicine	Fruit	permitted within the fruit category	Terminalia bellirica	Horner, 1951, p. 273; Dhammi ka, 2018, p. 170	Probabl e
hiṅgu	asafoetida; gum/resin medicine	exuded gum/resin	permitted within the resin category	Ferula spp.; exact source species varies	Horner, 1951, p. 273; Dhammi ka, 2018, p. 202	Probabl e at genus level; species uncertai n
tela from tila	sesame oil; medicinal oil	expressed seed oil	one recogniz ed source of medicina l oil	Sesamum indicum	Zysk, 1991, p. 74; Dhammi ka, 2018, pp. 110– 111	Probabl e

The table demonstrates why botanical lists should remain cautious. The confidence level concerns lexical-botanical correspondence, not therapeutic efficacy. It also shows that a medicinal “plant” may appear as a raw organ, an exudate, or a processed oil. The Vinaya’s medicinal world was therefore technological as well as botanical: grinding, expressing, boiling, mixing, filtering, storing, and applying were regulated acts.

4. Buddhist Monastic Medicine and the Ethic of Care

The medical rules express an ethic of care through practice rather than through a modern theory of health care. A problem arises, the community recognizes a need, a permission is formulated, and misuse is restricted. In this sense, care and restraint operate together: permission is tied to necessity, and necessity does not suspend discipline.

Care is also communal. Renunciants who no longer live within household structures depend upon fellow monastics, teachers, lay supporters, attendants, and, at times, physicians. Salguero (2017, pp. 4–5, 118–119) presents Pāli materials in which ordinary nursing and medicinal care exist alongside spiritual practice. The Saṅgha is neither a hospital in the modern sense nor merely an aggregate of isolated meditators; it is a disciplined community in which the care of the sick is institutionally accommodated.

The regulation of medicines and equipment also limits the conversion of care into luxury or accumulation. Goods and tools may signal status, stored food may resemble wealth, and dietary practices may expose the Saṅgha to criticism. Monastic care therefore has bodily, collective, economic, and social dimensions. Medicine enables renunciant life to continue, but it remains subordinate to necessity and moderation.

5. Comparison with Āyurveda

Comparison with Āyurveda is strongest at the level of shared materials, categories, and practical concepts rather than demonstrable textual dependence. Zysk (1991, pp. 73–83) notes parallels involving roots, fruits, resins, and salts, while Sharma (1992, pp. 118–119) describes comparable classifications. Such similarities suggest participation in a wider Indian medical culture in which food, plant substances, preparation techniques, and bodily effects were interconnected.

The differences are equally important. The Vinaya is primarily a disciplinary text that authorizes or restricts actions within the monastic community. Classical medical texts, by contrast, develop theories of disease, properties of substances, diagnosis, treatment, and professional practice. The Vinaya often lists observable symptoms and permits remedies

without supplying an elaborate medical theory. Later commentarial traditions may interpret such cases in humoral terms, but those explanations should not automatically be read back into the canonical rule.

The direction of influence is difficult to establish. Zysk argues for a significant contribution of non-orthodox ascetic traditions to the development of empirically oriented Indian medicine (1991, pp. 3–8). The Vinaya's case-based regulatory style is relevant to that proposal. Nevertheless, similarities could also reflect shared markets, itinerant practitioners, common ingredients, culinary technologies, and later textual development. The evidence supports interaction and participation in a common medical environment more securely than it supports the claim that one complete system was copied from another.

Institutional context also differentiates medical ethics. Āyurvedic literature includes norms for physicians, patients, medicines, and professional conduct, whereas the Vinaya regulates a community of renunciants. The care of the sick is a point of intersection, but the social settings and textual purposes remain distinct.

6. DISCUSSION

First, the Bhesajjakkhandhaka reveals a distinctive regulatory classification. It moves among nutritional status, plant part, processed form, timing, and storage. This is not a modern pharmacological taxonomy, but neither is it a random collection. Zysk's term "materia medica" is useful if it is understood in a qualified sense: the Vinaya presents a normative materia medica concerned primarily with what may be used, by whom, at what time, for how long, and under what conditions.

Second, the text demonstrates that medicine in the monastery was materially organized. Grinding, boiling, expressing, filtering, mixing, storing, and applying substances required tools and procedures. The medical regime therefore consisted not only of named substances but also of regulated technologies and practices.

Third, botanical identification is the most delicate aspect of the analysis. Dhammika (2018, p. vii) notes substantial disagreement in correlating ancient plant names with modern species. A term may vary regionally, may refer to several related plants, or may later be aligned with a Sanskrit or vernacular name. Older botanical references may also employ superseded synonyms. Accordingly, familiar correspondences such as haliddā with *Curcuma longa* or siṅgivera with *Zingiber officinale* should be regarded as probable rather than certain. Historical identity, modern taxonomy, and therapeutic equivalence are separate questions.

Fourth, environmental interpretation requires restraint. The rules encourage economy, moderation, and need-based use of material resources, but they do not articulate a modern conservation policy. Sahni (2007, pp. 1–3) cautions against projecting contemporary environmental ethics onto early Buddhist texts. The Dalai Lama XIV's emphasis on responsibility toward natural resources and future generations may be understood as a modern ethical development, not as direct evidence of an ancient environmental programme. Finally, later lists of therapeutic uses should not be confused with the Vinaya's own claims. The canonical text often identifies a permitted class—root, leaf, fruit, resin, or another preparation—without specifying the particular disease treated by every named substance. Modern or later therapeutic indications may be valuable for comparative history, but they do not constitute direct evidence for the early Vinaya.

7. CONCLUSION

The Bhesajjakhandhaka presents a structured but non-systematic framework of monastic health care. It begins with five medicinal foods and extends to roots, astringent decoctions or extracts, leaves, fruits, gums or resins, salts, and the equipment and procedures required for their preparation and administration. These materials are not placed in a single “sacral” category; rather, their status is determined by need, material form, timing, method of use, storage, and disciplinary permission.

Comparison with classical Āyurveda reveals meaningful similarities in the use and classification of natural substances and in the continuum between food and medicine. These parallels point to interaction within a wider medical culture of ancient India, but they do not establish simple borrowing, chronological priority, or a unified system that can uncritically be called “Buddhist Ayurveda.”

Modern botanical identifications must remain provisional. The table below offers defensible correspondences while preserving uncertainty where the evidence does not permit exact identification. No traditional use discussed in this article is presented as modern clinical evidence.

Methodologically, the article brings plant names back into their disciplinary contexts and separates four levels of evidence: canonical permission, later historical interpretation, proposed botanical identification, and modern therapeutic application. Further research could extend this approach through comparative linguistics and comparison with Vinaya traditions preserved in other Buddhist languages.

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