# HEALTH CARE DEVELOPMENTS IN CHANGING THAI SOCIETY: BEYOND THE PHYSICAL

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## Abstract

This paper[1] examines how health care in Thailand is currently at a significant and even pivotal stage of its development, as a result of attempts to improve services by integrating traditional medicine and conventional medicine. In addition, the changing roles of traditional healers in the light of government initiatives are considered, as are ways in which issues of spirituality have been neglected by mainstream health care until recently. Despite what might be viewed as a series of dichotomies into dualistic categories of mind and body, modern and traditional, and traditional healer and conventional medicine practitioner, emphasis is on how certain people are working to transcend these categories by adopting integral perspectives.


## Introduction

Aggregate health-related statistics reveal that Thailand's "health profile", as measured in physical terms, has largely improved over the past half century, with it essentially having completed its demographic transition. In fact, by mid-1980 Thailand–like Sri Lanka, China, Costa Rica and other countries with significantly reduced infant mortality, and increased life expectancy and literacy rates–was lauded as a developing world "superior health achiever" (Caldwell 1986). Provision of basic public and primary health programmes–including water and sanitation, immunization and maternal and child health–has helped reduce morbidity and mortality from infectious diseases, especially diarrhoea and respiratory diseases. Furthermore, a "health transition" has occurred, with (apart from the

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recent growth of HIV/AIDS as a major cause of morbidity and mortality) a shift from communicable diseases to non-communicable ("lifestyle") diseases and accidents, such as cardio-vascular diseases, cancers, occupational diseases and road accidents. In spite of these trends, with a focus on measurable physical conditions, many health care practitioners in Thailand today say that it is difficult to judge whether there have been improvements in the *quality* of health of the average person. This is especially so when considering aspects of mental health, and even "spiritual dimensions", often neglected in mainstream health care discourse and practice–the mainstream fundamentally consisting of conventional medicine (biomedicine). By the "spiritual", this refers to what in Buddhist terms relates to well-being associated with eliminating greed, anger and delusion; developing compassion, mindfulness and wisdom; and extinguishing *dukkha* (imperfection or suffering). Thailand has a long history of religion and healing going hand-in-hand, especially with Buddhist influences on health, including the condition of the mind and the social role of individuals in society. Nonetheless, the spiritual domain, and healing in such terms, has been mainly left to traditional healers and monks who heal.

Health care statistics themselves might not lead to valid conclusions due to the process of "medicalization". Medicalization implies: "…the way in which the jurisdiction of modern medicine has expanded in recent times and now encompasses many problems that formerly were not defined as medical entities" (Gabe and Calnan 1989:23). Medicalization may negatively affect individual and community self-reliance in health care, with implications in terms of reduced ability to cope with disease and misfortune. This is especially so since medicalization arguably "…now includes a wide variety of phenomena, such as many of the normal phases of the female life-cycle... old age, unhappiness, loneliness and social isolation, and the results of wider social problems, such as poverty or unemployment" (Helman 1994:156–157). As a result–at least in part–of this, in Thailand the number of in-patients visiting government hospitals lately has increased and "the trend is that this number will rise continuously" (Heath Systems Research Institute Bulletin, June 2000:3). Many factors contribute to such trends, and even sectors of the government suggest that overuse and misuse of antibiotics, analgesics and cold remedies (all widely promoted by advertisements) are much to blame (ibid:3). The implications are that medical conditions are reduced to physical disorders, and the remedies promoted follow similar reasoning–such as working with chemicals in medication to alter chemical imbalances in the body/mind, including those that are said to cause depression and anxiety. Concerns are also expressed regarding the overall lack of morality in society, with materialism and selfishness bringing about much disharmony. In some senses this stretches to much of mainstream health care, where doctors, clinics and hospitals have become disproportionately wealthy, and *caring* is often lacking.

Turning to access to health services, Whittaker (1999:117) argues that inequality has increased and "…diseases of poverty continue to be the primary causes of morbidity and mortality." This, many socially-orientated individuals and groups propose, is just one aspect of the dilemmas facing Thai health care today. While poverty is indeed closely correlated to a lack of material requirements, another dimension which is stressed as vital by many critics is the significance of developing awareness–through contemplative spiritual practices, including meditation, which are generally neglected–and working on the root cause of the factors that contribute to disease and misfortune. This would also allow people to see beyond physically-measurable criteria and look at the mind, ethics and education to change behaviour for individual and social benefit. In fact, despite the criticisms, there are signs of what might be considered positive developments, and to overcome existing shortcomings elements of the mainstream, as well as certain people on the "margins" (especially traditional healers and monks), are seeking to breach the gap between the physical and the spiritual, as well as that between practitioners of conventional medicine and traditional medicine.

## Health care reform and a more open aproach to healing

Disagreement as to *how* to remedy imperfections in the Thai health care system exist, yet there is general consensus (evidenced by conferences, media reports and recent writings and discussions involving academics, Thai Ministry of Public Health [MoPH] officials and health care workers) that Thailand needs to develop a new system of medicine. Regarding the mechanism to make this possible, the MoPH promotes what is referred to as health care reform or "*patirūp rabob-borikān sukhaphāp*" (literally, "reform of the system of health care services"). The MoPH Office for Health Care Reform was inaugurated in May 2000 in order to spearhead the implementation of the national health care reform movement. Complaints that the existing system is outdated, not cost-effective, inefficient and unfair are voiced by a variety of health care practitioners and other interested parties. At the same time, proposed remedies tend to centre around the increasing focus on preventive medicine, raising levels of education and improving the health care system through reform of bureaucracy and the way medical services are delivered. Another related phrase commonly used with the aim of improving the system is "*kān pheung ton-eng*" (self-reliance) where individuals and members of local communities are more in control of their health care exigencies.

Several prominent writers, as well as active health care personnel, point to the need to empower people and improve their overall health and well-being by encouraging consideration of spiritual matters. Prawet (2000:4) cites the WHO declaration: "Health is complete physical, mental, social and spiritual well-being",

and adds that only through "self-transcendence", self-sacrifice and spiritual development are real happiness and harmony possible. Otherwise a combination of selfishness and lack of peace in families and communities will bring about deterioration in mental health. Prawet (ibid:23-24) also suggests that conventional medicine practitioners should be more open to alternative and complementary forms of healing, in particular learning more about traditional medicine, so that Thailand can be more like China and India in integrating their traditional medical systems with conventional medicine.

The MoPH (in a 1999 booklet distributed to health care centres across Thailand) specifically targets self-reliance, by encouraging greater community involvement to develop sustainable health care. This, it proposes, needs to be done by means of MoPH officials, community health care volunteers and people with indigenous healing knowledge working together. Therefore, the MoPH states, traditional healing knowledge and techniques may be combined with modern ones to bring about the best results (ibid:18). To resolve problems in the health care system, the MoPH suggests health care workers adopt a format to evaluate existing self-reliance, based on five qualitative indicators (related to human resources, funding, management, the process and transmission of knowledge, and local people themselves). This process of evaluation may lead to a large database, but several people working in government health care centres and with interest in instilling self-reliance and promoting community development are not particularly optimistic that it will significantly influence the average person. It might be because the MoPH in its official booklet (1999) adopts a standard social science approach without reference to health beyond that largely considered in physical terms, or reference to spiritual health and getting to the core of effecting attitude changes.

To prevent disease/illness, Jarat (2000) suggests that people should change their lifestyles, not only *vis-à-vis* diet and physical exercise, but by considering health more holistically and with longer-term perspectives; this, he says, may be new for conventional medicine, yet has always been stressed in traditional medicine. He (ibid:23) proposes that health care has become commercialized, largely depending on market mechanisms, despite knowledge of their imperfections, and this is why people should consider ethical matters as fundamental. Furthermore, he (ibid:33) feels that health care reform strategies may be effective only if people recognize internal (self-healing) energy (something considered fundamental by traditional healers) and integral connections between physical and mental phenomena and the crucial role of the mind in healing. On the other hand, Thara (1998:64-65), emphasizing developing complementary (traditional) medicine and integrating it into the national health care system, recommends that "…the concept of integrative medicine should be introduced in the medical and paramedical curriculum" and policy-makers should actively promote it. To do this, knowledge

of what constitutes traditional medicine is required, and elements of the government are in many ways working to make such knowledge more accessible.

## Recent developments in traditional medicine

Traditional medicine in Thailand–for the purposes of this article "traditional medicine"– can effectively imply two medical systems: *phēt phēn-thai* (literally "Thai medicine"), or what is known as Thai traditional medicine (TTM), and *phēt phēūn-bān* ("local community medicine"). The latter is practised in more "folk" terms without government endorsement, while TTM is state-sponsored and regulated by the National Institute for Thai Traditional Medicine (NITTM) in the MoPH. TTM is said to involve "the traditional philosophies, bodies of knowledge, and modes of practice to care for Thai people's health and cure their diseases and illnesses, which are congruous with the Thai way of life and Thai culture" (NITTM 1996a:7). Such an approach to traditional medicine purportedly focuses on the value of old texts and the transmission of knowledge from "forefathers", while claiming to be a holistic system, working to achieve balance in body and mind. Not all health care workers, academics and traditional healers are content with official views of TTM–which are at times considered or intended (by those in authority) to encompass all traditional medicine in Thailand–since they (particularly those in peripheral regions) feel that it is just another form of homogenization and domination of Central Thai culture within national boundaries. Consequently, they tend to refer to much of traditional medicine as a diverse group of different *phēt phēūn-bān* and emphasise local beliefs, rituals and practices. Standardized MoPH TTM exams favour the Central Thai model, particularly by adopting Central Thai names and concepts related to medicinal herbs. In rural areas far from Bangkok herbs have their own particular names, different dialects/languages are spoken and distinct therapies are practised; many related to beliefs in supernatural powers are certainly not discussed in TTM textbooks.

Beyond TTM's conceptual, technical and legal framework traditional medicine exists as a diverse entity, hence a medical system (involving numerous sub-systems) with many similarities to TTM, but effectively self-regulating and, despite several homogenous characteristics, possessing manifold heterogeneous traits. A further term, *phēt phēn-borān* (literally "ancient/traditional medicine"), often describes traditional or indigenous medicine in its broadest context. However, objections that this term suggests an outdated system, lacking capacity to develop, led to TTM being adopted and promoted by the MoPH. Hence, argue Sawapa et al. (1996, cited in Mali 2000:1), its status was raised to the level of "Chinese medicine". This reasoning holds little weight, considering indigenous Chinese medicine is both officially and commonly called traditional Chinese

medicine (TCM). Nevertheless, it reflects that, *vis-à-vis* China (and to a certain extent India), the Thai government had long neglected traditional medicine. The name change also served as a break from the past by introducing a more systematic, better-organized and dynamic traditional medicine, fulfilling the criteria of both having traditional legitimacy and being compatible with modern health care needs. Furthermore, it might indeed offer opportunities for increasing awareness, especially in what might be called the expanding middle class, that health can be considered in a manner not restricted to physical criteria.

Prior to the NITTM's establishment in March 1993 and changes in government attitudes towards health care in the 1980s that preceded this, the MoPH, with its "scientific and rationalist bias" (Irvine 1982:47) paid little attention to traditional medicine. In fact, though it makes no mention of its independent dynamism, one NITTM publication (1996a:6) sheds light on official policy by stating: "For almost a century, Thai traditional medicine had been a nonformal medical system, dormant without continuous support and development on the part of the government." Based on research in the mid-1980s, Brun and Schumacher (1987:235–237) state that attitudes of the government and many Western-trained members of the "medical establishment", and the "dwindling number" of licences in traditional medicine issued by the MoPH "…could well be interpreted to show that the ministry actively follows a policy aimed at limiting the number of general practitioners of the traditional school by making examinations so difficult that students cannot pass them." What such comments suggest is that mainstream Thai health care was principally geared toward conventional medicine. With the NITTM, the situation may have somewhat changed, though many challenges still lie ahead. For instance, NITTM director Dr Pennapa Subcharoen feels that it is difficult to make most MoPH policy-makers accept TTM, and recently expansion of NITTM activities have been hindered following reduced funding due to the mid-1997 economic/financial crisis. Nevertheless, during 1994–1997 the number of Provincial Health Offices (MoPH branches) with TTM "development activities" increased from 32 to 75, or full coverage (NITTM n.d.:33). This trend followed the ideal of what the seventh and eighth National Health Development Plans (1992–2001) heralded as a "Decade of TTM", in which: "The overall objective is to preserve… [TTM], the national heritage and wisdom of Thailand, besides developing it to become an integral part of the present national health care and primary health care system, leading to self-reliance within the health care delivery system both at national and community level" (NITTM n.d.:19). The extent to which this has occurred, though hard to evaluate accurately, is varied, with only certain hospitals and health care centres offering traditional medicine therapies. Certainly there has been an expansion in the availability of traditional medicine in such places but, as will be seen, this may not represent a widespread break from the established practice of looking at disease and illness in physical terms.

## Qualifications, licences and traditional healers

While traditional medicine may be experiencing a revival, other developments related to how traditional medicine is offered as a service are changing considerably. Across Thailand, as the population becomes more educated and the economy moves toward greater value-added production with skilled labour and a service orientation, demand for academic and professional qualifications—for competitive edges in employment, for self-esteem or to fulfil government criteria—continues to rise. This is also the case with regard to traditional medicine.

Until the NITTM's inauguration, traditional medicine, though not actively promoted, was regulated to a certain extent with examinations and licences for those wanting officially to practise pharmacy (*pēsachakam*), general medical theory (*wēchakam*), midwifery/obstetrics (*kān-phadungkhan*), fields still recognized today. There are also certificates attainable after taking massage courses, but the government was and still is less concerned about regulating this form of therapy, though many reputable private centres exist. Most controlled are pharmacy and general medical theory, and their exams are considered demanding for traditional healers. A qualified/licenced pharmacist can legally make herbal concoctions and run a shop selling traditional herbs, a potentially lucrative business requiring quality control, and hence official regulation. One qualified in general medical theory, attainable after becoming a licenced pharmacist, can diagnose patients and offer various therapies, including advice on diet and lifestyle. Pharmacy and general medical theory exams are usually taken after approximately one and three years study respectively. However, many healers take exams repeatedly, some not passing after five or ten years. Included in this group are recognized "experts" who ironically even teach at the MoPH. Many are simply unfamiliar with exam formats and modern ways of intellectualizing knowledge, by adopting particular classifications and hypothesizing or reifying medical contexts without the tangible and subtle manifestations associated with actually being with a patient. Moreover, some complain that to pass exams one needs only memorization, while ability to deal with herbs (a "hands-on" approach) is not tested. Certain more elderly healers are simply uninterested in exams, knowing their memories might fail them (though confident that in practical situations they know the appropriate herbs and treatments to prescribe to patients) or because they are barely literate. Many healers in peripheral regions commonly cite differences in herbal nomenclature between Central Thai (the language of official exams) and local dialects/languages as an obstacle.

The general MoPH policy appears relatively *laissez-faire* regarding uncertified healers, especially older ones, as they often provide basic, low-cost health care services without instigating controversy. Similar situations exist regarding healer monks, who cannot be officially certified or recognized as healers

since monkhood rules forbid involvement in "professions" and "worldly pursuits". This is purely a formality (or lack of it), and many monks are known for their skills (especially with herbs and using powers of the mind to heal) and are sometimes actively involved with (traditional) healer societies. Nearly all districts in Thailand have such societies (frequently forming part of larger provincial societies or even cross-provincial society networks) that operate as regulatory units with specific codes of conduct. These relatively recent developments tend to be welcomed by the MoPH as they offer some order in the system. For instance, the Chiang Rai-Phayao healer society, established in 1994, has over 400 members. Only 204 members have "official" cards and are registered (with details of their background, skills and healing experiences), but some records of other members, such as name and address and main field of practice, are also kept. If police/authorities ever query card-holding members and the issue is not particularly serious, Ajarn Singkham Yoatmoondee, the society president, is telephoned, and, depending on healers' existing records, might be able to help. For those without cards it is more complicated, and for healers outside the society (most healers in the two provinces, and generally considered less reputable by society members) they are basically alone if questioned. Many healers who are not society members, in these provinces and elsewhere, are often farmers with relatively limited knowledge of traditional medicine (usually learnt from parents or grandparents) and they treat people only occasionally and for minor ailments. Some, though, are very skilled, yet feel no need to join societies.

Certain healers, as in the case of those with additional forms of employment or those with an established client base, are simply uninterested in being officially recognized. On the other hand, many society members, especially in remote areas, complain about the effort, cost and time required to attend meetings (usually held monthly) and some even doubt whether it is all worthwhile, again a matter of costs versus benefits (prestige, security, new information, etc.). Financial concerns sometimes strongly influence healers' decisions, which introduce a common anxiety: traditional medicine's commercialization. Images of the past created by both healers actively practising and writers on traditional medicine imply that healers, though sometimes relatively wealthy and of high status, practised their art out of ethical imperatives, and their therapies, beside possible accidents, were natural and safe. This was (and is still said to be) particularly so with herbal remedies that, despite acting more slowly than modern drugs, have few or no side effects. Having said this, nowadays various stories of healers mixing their herbs with antibiotics and steroids to make their medicines more powerful circulate, with also comments that the "pumped-up" medicine may initially have a rapid and apparently beneficial affect for those with asthma, aches and other complaints. However, such judgement may not take account of long-term effects,

which include osteoporosis, high blood pressure, ulcers and the accumulation of body fat. The recommendations tend to be that in order to avoid such risks one should look for traditional medicines that on their label bear clear FDA [Thai Food and Drug Administration] registration and the name of the manufacturer.

Undoubtedly the nature of the media increases awareness of irregularities performed by "charlatans" and devious practitioners, but what concerns many healers is the common public obsession with material possessions, physical characteristics and socio-economic status. This goes against the ethical imperative of much traditional medical knowledge and disregards the significance of the mind in determining health and well-being. It is also something which ultimately cannot be controlled by any form of exams or licences. Nevertheless, it is likely that exams and licences will become more significant in the years ahead. It should be mentioned that even within the TTM framework, where ethical issues feature, there is often flexibility to adopt healing techniques far removed from what is taught in official texts. This does not overcome the possibility of malpractice, but it could be encouraging in terms of promoting open-mindedness to a greater variety of forms of health care and even relevant spiritual considerations.

Dr Pennapa stresses that the NITTM's objective is not to eradicate *phēt phēūn-bān* practices incompatible with the general rubric of TTM, because each region has distinctive cultural traditions. This issue is actually discussed in the introduction to the NITTM's "Handbook for Practising TTM", where it is states that TTM "includes" *phēt phēūn-bān* practices, and these are recognized as specific to Thailand's different regions (NITTM 1996b: 10). Rhetoric may not indicate practice. However, healers, particularly those relying on "supernatural methods" and not adopting empirically scientific reasoning when discussing disease/illness with patients, often show signs of *fearing* modern developments. They are generally accustomed to holistic modes of thinking to the extent that they see conventional medicine–with its Western-influenced, rational, analytical approach–as segmented, rigorous and revealing, and ultimately harmful to their traditional way of life. Those confident in their knowledge (through analytical thinking, balanced by faith in their teachers/tradition, awareness of spiritual considerations and an understanding of a more integral approach to health that includes the strengths of both traditional and conventional medicine) seem less concerned about conventional medicine being a threat, other than it not accepting traditional medicine and ignoring benefits of integrating the two systems. Even those in this group without licences are not so bothered about government pressure, actual or perceived. This is often reflected in attitudes of more liberal health care officials, conscious of the inherent ethical nature of such individuals, and their success in healing. Generally, the potential status, security and financial rewards of being licenced or employed at government health care centres are factors many healers consider.

Nonetheless these are counterbalanced by possibilities of having to compromise in the techniques they feel free to adopt, especially those dealing less with physical disease/illness, such as *sū khwan* (calling back the spirit-soul), *sēūap chatā* (extending fortune) and using *khāthā* (mantras/incantations).

Herbal medicine is potentially the area of greatest concern but least contention. The concern is that limited regulation, whether jural in conventional terms (i.e. with regard to FDA involvement and quality control) or ethical terms (i.e. following *sīladhamma*, or Buddhist morality), may lead to opportunism and worse health by any standard. The lack of contention derives from the belief that quality should actually improve, despite threats by powerful pharmaceutical companies with access to traditional herbs who might undercut prices healers charge to sustain their activities, and out-perform them with more comprehensive marketing and distribution strategies. Although the legal framework can be tightened and traditional medicine schools can teach morality, many healers stress that a true understanding of *sīladhamma* cannot be attained by force nor imposition, but rather through promoting wider awareness, self-reliance, socially-oriented education and reflection on spiritual/metaphysical matters. To this end, such healers use their interactions with patients as opportunities to provide education about the role of the mind in health and how to increase all-round well-being and prevent future disorders.

## Variations between tradition and modern healers and ways

Writers as early as Boesch (1972:6) suggest that doctors of conventional medicine form part of "service elites", with a significant role in the development process. They often feel self-confident, behave arrogantly, mix official and private practice (reducing official consultation times and health care standards) and consider themselves the "cream of society", practicing the most esteemed profession and avoiding underdeveloped provinces (Goldschmidt and Hofer 1972:5–9). Even today people voice similar complaints. The perceived "elevated status" of conventional medicine practitioners creates a social distance between them and patients, particularly less-educated, rural ones. Consequently, in communication semantic and cognitive barriers exist and the often-mystified patients generally behave passively and deferentially. Furthermore, practitioners may face conflicting loyalties, as members of various groups, including their families, their profession and their hospitals. This could mean minimum loyalty directed to the disadvantaged patients, who are purely anonymous individuals (cf. Boesch 1972:7). Nevertheless, the above argument is primarily aimed at practitioners dealing with somatic disorders and it should be mentioned that certain practitioners are actively involved in emphasizing issues of spirituality to improve mental and spiritual health. Evidence of such

"enlightened" ideas and practices exists among a small though possibly growing number of relatively young psychiatrists in both peripheral provinces and Bangkok. These practitioners promote integral perspectives and support initiatives to encourage practices like meditation, Buddhist rituals, and traditional therapies which include spiritual components, although they frequently encounter resistance from colleagues who frown on anything but evidence-based medicine with empirical backing.

Unlike most conventional medicine practitioners, traditional healers, especially in rural areas, generally form part of wider communities whose underlying social ethic promotes mutual interdependence. Hinderling (1973) argues that when healers and patients interact, as a norm no conflict occurs; while communication is usually easy and relatively uninhabited. Moreover, the "[e]thics of Buddhist-Thai medicine ensures that a [traditional] doctor, especially a minor one, does not practice primarily for financial reasons but for social reasons, out of sympathy for patients or perhaps to achieve *'bun'* [merit]" (ibid:83). Yano (1999:174) argues that in the "traditional model of medicine" healers, patients' families and the "larger community" were all "…responsible for providing the patient with compassion, comfort and care." In such settings, Kleinman (1980:364) suggests: "Sickness [and healing] is best regarded as semantic networks (culturally articulated systems) that interrelate cognitive categories, personal experiences, physiological states, and social relationships... Biomedical and psychiatric reductions make it impossible to study healing from this cultural standpoint."

These settings are found in Thailand today, as people try to negotiate their lives in a changing society and amid uncertainty. What might add to that uncertainty is not knowing and trusting healers as well as in the past, when communities were more tightly knit, and fear that the healers do not necessarily behave as ethically as they might have in former times. Despite this uncertainly, people, especially in rural areas, may feel more comfortable with and find it easier to relate to healers than conventional medicine practitioners, where language, image and physical surroundings are more controlled, following strict professional and hygienic criteria. This introduces another dimension. Critics voice the concern that large and powerful companies, driven by profit, encourage the consumption of goods that are often unnecessary, potentially harmful and aimed at inducing narcissistic satisfaction–and modern pharmaceutical enterprises may operate likewise. Turton (1984:40) notes that drugs are over-imported, over-stocked and marketed in an unregulated fashion, so that "…in many cases Thailand is used as a testing ground for dangerous drugs." The enterprises, argue many healers, continue promoting their medications, ignoring placebo effects and even influencing behaviour of conventional medicine practitioners by highlighting evidence from clinical research that supports their interests. Healers, struggling to make their herbal remedies comply

with FDA regulations and compete with mass-produced medicines of pharmaceutical enterprises, are frequently frustrated by this. Proponents of traditional medicine say that ample evidence shows how meditation, exercise, a balanced diet of unprocessed foods and other practices conducive to health, cost little and would reduce dependence on medical services. Nevertheless, they add that interest groups with political and economic strength often control the information that influences the general public.

Statistics can powerfully influence attitudes, but medicalization renders making conclusions difficult, even using implications of empirically-provable health data, themselves largely bound to physical phenomena. Cassell (1976) differentiates between the terms "disease" and "illness", explaining that the former (determining doctors' perspectives) is an objective, scientifically-quantifiable entity, while the latter is the subjective response of patients, loaded with cultural and social meanings. It could be added that the former term is more geared to somatic characteristics than the latter. Conventional medicine practitioners, educated in clinical settings to see patients and diseases in value-free objectified terms (cf. Good and DelVecchio Good 1993), usually work in relatively impersonal hospital-like environments. Moreover, the "modern professional practitioner" is taught to *cure* rather than *care*, since this "…profound distortion of clinical work is built into the biomedical training of physicians" (Kleinman 1980:363). With emphasis on *curing* and *maintaining* the "machine-like" body, amelioration in *physical* health and control of pain through painkillers would indeed point to general diachronic improvements in recent years.

Using approaches largely void of modern/empirical medical and scientific dimensions, mainly practicing in rural homes or temples and regularly in contact with patients, healers and monks arguably work more with "illness", helping patients understand the meanings of poor health. This usually necessitates moral and spiritual perspectives. Hence many monks and healers are less concerned about judging things using physical criteria and point out that mental and spiritual health has not necessarily improved and may have even deteriorated. Nevertheless, they do not stress pessimism in adopting such an attitude, yet rather the need to use it for its didactic worth and see the benefits of employing environmentally-friendly and socially-aware traditional teachings, while being cautious of apparently progressive and convenient aspects of modernity. This is especially so with regard to trends for greater infatuation with materialistic pursuits and concern with bodily image.

Almost all practitioners feel that health care in Thailand is changing rapidly, with greater emphasis on empirical evidence. Healers particularly voice this, alone, at group meetings, and participating in projects to evaluate and assess their shifting position in the midst of new government regulations towards their practice. Regarding data collection for empirically-provable evidence, science and con-

ventional medicine have achieved wonders and will continue to do so. For instance, certain healers and monks say that unravelling the DNA code will lead to various cures; yet trouble will arise as long as behaviour is driven by *tanhā* (desire) and attachment to the body. They feel that Buddhism, like science, has its hypotheses and one is cautioned against blind belief; but even supposedly well-educated and clever people become fooled by science, just as many are fooled by "charlatan" healers and "spiritual teachers", whether they be monks or lay people.

From the above analysis health care in Thailand appears to be dichotomised into categories of "good" traditional medicine and "poorly-suited" conventional medicine. Over-generalizing or denying that conventional medicine practitioners and healers make up diverse groups of individuals does not accurately reflect existing circumstances, particularly the fact that traditional medicine and the way it is practised (especially in commercial terms) is evolving. Rather it shows extremes, as perceived by certain writers, and possibly affected by the alienation of modern (particularly urban) depersonalised life, and popular Thai nostalgia for a past commonly portrayed as pervaded with happiness, harmony, abundance and integrity. Helman (1994:88) proposes that such nostalgia for a sense of community and a caring extended family appears widespread in an increasingly impersonal and industrialised world. Despite these trends, developments that encourage improved overall well-being and integrating traditional medicine with conventional medicine exist.

## Spreading traditional medical knowledge and spiritual awareness

Concerning the integratation of traditional medicine into the national health care system, several challenges remain, in particular coping with risks that it may be forced to develop into a more empirical system with greater emphasis on physical disorders. Statistics show that in 1997 official TTM, as practised at public health service offices, primarily treated "diseases and symptoms" related to the "respiratory system", the "dermatological system", the "gastro-intestinal system" and the "musculoskeletal system" (NITTM n.d: 35). These figures by no means represent what healers effectively practise across Thailand, but show that, even given the NITTM's good intentions, TTM is being forced to adopt biomedical terminology and somatic reductionism (cf. Klieinman 1980). It may indeed seem that "…traditional medicine is being swallowed up by the modern" (Brun and Schumacher 1987:239). Yet there are signs that certain establishments adopt more liberal approaches to traditional medicine, letting it almost regulate itself via community supply and demand.

This is so in the Mae Orn Sub-District Hospital in Chiang Mai province, where diverse traditional medicine therapies beyond those officially endorsed by

TTM are common practice. For example, there are healers specializing in treatments such as *hēk*–involving a tiger's tooth, deer's horn or other knife-like implements being scraped along the skin to expel toxins–while at the same time openly discussing *rit* ([supernatural] potency/power) and its applications. Many therapies used have a physical orientation, but, during healing, ethical matters and spiritual considerations are also stressed, without objection by the medical authorities. Moreover, some healers employed at the hospital are uncertified and ironically working under the auspices of TTM projects and treating patients in ways not included in official documents nor tested in exams.

Another case in which traditional medicine is actively promoted and even used as a complement to conventional medicine is the Phayamengrai District Hospital in Chiang Rai province. This, under the auspices of its director, the late Dr Thara Onchomchant, by the end of the 1990s was Northern Thailand's best-known example of integrating traditional medicine and conventional medicine. However, notwithstanding the hospital's successes, after more than fifteen years promoting herbal medicine and massage in district hospitals, interested parties say that they still face an uphill battle convincing policy-makers to invest more in traditional medicine and integration. Consequently, for the time being, despite plans for widespread availability and awareness of traditional medicine and having it as a viable and desired form of therapy, this only appears to be occurring in relatively localized situations. To conclude and see what are some of the main obstacles to increasing spiritual awareness, to integrating traditional medicine and conventional medicine and exploiting the potential of the former more effectively, two healers and their experiences are discussed.

Ajarn Pinkaew Tannuan, an influential healer in Chiang Mai province, considers traditional healing knowledge part of his family heritage. With four years of state education and no other formal qualifications he is a ninth-generation healer in an unbroken lineage. He was a *samanera* (novice monk) and a monk (each for a year), and attributes most of his knowledge to family members and other teachers, including monks, as well as his self-study and meditation. He has three sons; the eldest (22 years old) is a monk, the other two (20 and 16 years old) have studied traditional healing with him and are helping him with a herbal medicine "factory", where herbs are produced, processed and packaged. Ajarn Pinkaew views modern scientific knowledge as just one of many types of knowledge useful in promoting health. He regrets not speaking English and is guaranteeing that between his sons they have the knowledge and skills to become competent in Dharma (Buddhist teachings), traditional medicine, English, computer usage and technicalities regarding operating the factory. He feels that traditional healers must change with the times to survive, and is seeking contacts with people abroad with potential interest in his herbs (he already has experience exporting herbs to Japan). He also

has been the "subject" of a Master's degree dissertation (Tanachai 1999) by a relatively well-known researcher who spent six months studying with him. Nevertheless, he mentions that he has had unfortunate experiences with certain Thais who "used" his knowledge and took advantage of him. This has made him more prudent and ever more aware of the need for morality and the realization of how health and well-being go beyond material and physical considerations.

Walking with him near his "factory" he points out dozens of herbs in the surrounding vegetation, saying that knowledge about their healing properties can be learnt by memory, but really to understand one needs access to "higher/transcendental" knowledge. He feels that in Thailand such knowledge is valued less and less. Thus, unlike certain others, fearing "theft" of knowledge, he is willing to establish links with foreigners. This, he believes, if done properly and through the right channels, could lead to greater recognition of Thai traditional medicine abroad (like TCM), and ultimately would make Thais change their attitudes and accept traditional medicine more. Ajarn Pinkaew regularly attends meetings with high-level MoPH officials and helps in the procedure of quality control of herbs. He views this as one side of traditional medicine's development, though he sees ethical "regression"—regarding healing in general and its uncontrolled commercialization—as another side. He says that being a traditional healer does not involve religion (*vis-à-vis* many rituals and "external" activities), but is rather associated with determination in one's heart to help others. He mentions that Buddhism points to *paramattha-sacca* (ultimate reality) so one can see it; but effectively if one sees it one must have an *attā* (self). Thus, the only way to follow Buddhist teachings and transcend the *attā* is to "realize" *lokutara* (the supramundane/transcendental), something that (unlike the "mundane world") cannot be conventionally measured and tested in laboratories. He feels that the best way would be for conventional medicine and traditional medicine to work together on the level of medication and healing techniques. However, beyond the body and on the level of mind, an abstract area where teaching is harder, knowledge comes from using Dharma in dealing with everything, traditional and modern.

Ajarn Prasart Tetyaem, from Lopburi province, with nine years of state education and a year as a monk, unlike most healers has qualifications/licences in pharmacy and general medical theory. He believes that traditional medicine faces similar problems to those suggested by Ajarn Pinkaew; but, living closer to Bangkok and the MoPH, he favours an approach working with traditional medicine students within Thailand. These are mainly people from Bangkok visiting his home on MoPH-organized "study tours". He realizes traditional medicine must change with the times, yet says that this can only be in the way it is taught, classified and regulated, and how patients are treated. The core of traditional medicine, he says, involves unchanging truths taught in Buddhism, which address issues of the mind

and how behaviour and health are determined by *karma* (volitional action). Regarding his experience, Ajarn Prasart says that, like all knowledge and all herbs, it comes from nature; thus, he cannot keep it because it belongs to nature and the world (global society). He expresses interest to teach anyone willing to learn by saying that anyone wanting the knowledge can take it, though he feels that they should then use the knowledge to help others. He also feels that working *with* the MoPH and their plans to "modernize" traditional medicine is best. Whenever he visits the MoPH and meets professors and conventional medicine doctors, he tells them he has little knowledge, though his knowledge is about "essential" traditional medicine. This implies the subtle source of the knowledge, which, like knowing the earth (the source of all herbs), allows one to understand what gives herbs their curative properties. Some people cannot accept that matters are so simple, and even criticize him; yet this, he states, is "good" because it allows him to see his "shadow". Likewise, when praised he does not take it seriously, as he believes that good, honest people do not offer much praise, just like skilled healers do not talk a lot (about themselves and their achievements). Consequently, he "selectively" deals with the MoPH, allowing him usually to stay at home, so that people can visit him and see how he informally works with his herbs and often treats patients just by talking about Dharma, teaching meditation and encouraging more integral perspectives than can transcend dualities.

Regarding traditional medicine's future, Ajarn Prasart is neither optimistic nor pessimistic, for this is not the way of *sīladhamma*. Nevertheless, having spent much time in self-study, he willingly teaches others how to do likewise and embrace modern changes being experienced in Thailand. He says that, formerly "masters" needed to know "disciples" a long time before teaching, but nowadays, with people liking things fast, this is no longer possible. However, everything around one can be used in learning, and with arguably more going on there are more potential lessons; if one can find and witness stillness in all movement and discriminate between the useful and harmful. For Ajarn Prasart, any increase in scepticism, as that inherent in scientific inquiry, can help eradicate impractical traditional superstitions that obstruct development of *paññā* (wisdom), while treating new discoveries dispassionately. The "new generation", as individuals and groups, with rises in the extent and potential access to diverse forms of knowledge, can go either way: to eliminate *dukkha* or generate more of it. As for health care in Thailand, Ajarn Prasart–like several other healers, monks and more open-minded conventional medicine practitioners–feels that, through reform and other means, there is the potential for much improvement and a better understanding of spiritual issues that can bring about higher standards of health in terms of the body *and* the mind. To what extent that potential will be realized is difficult to gauge; nevertheless it requires people recognizing the risks of being limited to physical criteria.

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