

EJOTS

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Special Issue

**Transnational Health in Asia
Patients, Knowledge, Praxis**

Guest editor: Laurent Pordié (CNRS, Paris)

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Prologue

The European Journal of Transnational Studies (EJOTS) is an interdisciplinary journal that seeks to contribute to a deeper understanding of transnational processes as well as country-specific features. With the tight integration of various disciplines such as economics and political science, sociology, or legal and cultural studies, we want to highlight different aspects of current phenomena and enrich the perspectives of our readers to deeper insights.

Especially important in terms of the thematic focus of the European Journal of Transnational Studies is the scientific exchange between established and new EU member states. EJOTS would like to contribute to the steadily continuing process of European integration and is therefore actively committed to its intensification. Our aim is to promote a common European identity, based on the pluralistic traditions of Europe.

Scientifically based articles and practical relevance are not mutually exclusive. Herein, the European Journal of Transnational Studies sees its central task: the transfer of expertise to social multipliers. Our aim is to build bridges and contribute to a substantial deepening of existing knowledge. Thereby we want to shape and inspire political, cultural, and economic discourses in our society.

Spaces of connectivity, shifting temporality.

Enquiries in transnational health

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This article examines the fabric of transnationalism in the health field through the prism of therapeutic travel and the transnational production of medical knowledge and practice. It takes travel, occasional and virtual contacts across international borders to be important forms of transnational encounters. For this purpose, the notion of “space of connectivity” is introduced to highlight the intersections of transnational networks and circuits and the myriad ways space and time deploy themselves. Circulations within these circuits converge in situated nodal points, such as clinics or (virtual) classrooms, where connectivity between geographically mobile and immobile agents intensifies. These nodal points result from the crystallization of transnational social, material and technological formations in a particular place and at a particular moment in time. They are stabilized by motionless actors. By examining spatiality and temporality in these contexts, this article frames this special issue while opening up research avenues in transnational (health) studies.

The expansion of transnationalism as a form of linkages between people, places and institutions across international borders has led to numerous and unpredictable social formations and cultural encounters. Studies by the social sciences of the effects of transnationalism in the health field have largely shed light on the health – and more widely caregiving – dimension of migration studies (Cognet *et al.* 2012; Elliott/Gillie 1998; Evans 1987; Huang *et al.* 2012; Stilwell *et al.* 2003; Zimmermann *et al.* 2011), medical and wellness travel (Hodges *et al.* 2012; Naraindas/Bastos 2011; Roberts/Scheper-Hughes 2011; Smith-Morris *et al.* 2010) and the international diffusion and transformation of medical practice and procedures (Alter 2005; Digby *et al.* 2010; Petryna 2009). A growing number of academic publications today explicitly overlap and compare these areas of study, aiming to enrich both empirical materials and theoretical options (Dileger *et al.* 2012; Knecht *et al.* 2012; Pordié 2011a). This special issue is an addition to this literature. It examines the shapes and shades of transnationalism in a single set of essays stemming from distinct fields of enquiry in the social study of health and healthcare.¹ The articles brought together in this collection take Asia as the port of entry to explore the social and cultural dynamics of transnational therapeutic itineraries, as well as the production, transmission and transformation of medical knowledge and practices, as they circulate transnationally and experience strong and decisive global influences. These issues are addressed for both biomedicine and Asian medicine in a variety of ways ranging from cultural translation to market construction, or again from therapeutic innovation to distance education. This issue aims to add complexity to current understanding of health and medical practice as they face a “mobility turn” in social science research (Sheller/Urry 2006). Conversely, it uses health and healing practices as a prism so as to offer a critical reflection of transnationalism itself.

By examining spatiality and temporality in transnational health, this paper underscores the points of convergence that bind the following articles together, while building on transnational studies. A transnational space is complex, multidimensional and multiply inhabited (Crang *et al.* 2003), and comes in all sorts of

¹ This issue stems from a series of gatherings held at the Cluster of Excellence ‘Asia & Europe’ at the University of Heidelberg between 2009 and 2011.

shapes. What then is the peculiarity and architecture of space and place in transnational health? How do the temporality and cadence of human encounters in this context help to expand the epistemological range of transnationalism? To answer these questions, I will address location and network, circulation and connectivity, mobility and motionlessness. For this purpose, I will rely on both material presented in this issue and on empirical data stemming from the transnational health industry in India². These are privileged sites from which to observe the nature, intricacies and implications of transnational encounters.

The crystallization of socio-material assemblages

Transnationalism brings together two forms of spatiality often mobilized in social theory – regions and networks. While they were initially focused on the diminished role of the nation-state in ordering the world, transnational studies however helped in “grounding globalization”, in Michael Burawoy’s terms (2000), by allowing territory, land and nations to express themselves in globalization processes, and by revising false and overarching assumptions of the global as a completely deterritorialized phenomenon. Indeed, regions (and their inhabitants) play an instrumental role in shaping the global, in diversifying and complexifying it. In fact, it is well-known that global processes are at all times local processes embedded in territories, communities, households, individuals and objects. They are therefore not uniform, nor are they simply elements of a context that determines local practices from the outside. The global may then be seen as small and diversified rather than big and homogeneous (Law 2005). In these regions people, objects, ideas, policies or institutions circulate around vast and highly heterogeneous networks which move across the borders of nation-states. They follow circuits, shift direction and change meaning, get connected and transformed, and are often appropriated. Being mobile

² I have been conducting fieldwork since 2008 in various structures that target foreign interest and clientele: biomedical hospitals involved in the medical travel industry, ayurvedic clinics adapting their services to international patients, spas chains geared toward Indian upper classes and foreigners, and ayurvedic pharmaceutical companies reaching global markets.

and fluid, these people, things or institutions move from one place to the other³; but they are always anchored in specific (but changing) grounded spaces, which play an important role in defining them. Objects, for example, are context-specific as studies in science and technology have taught us. The status of an ayurvedic drug is modified when the drug follows a circuit that leaves India to reach a country with a different legal environment; from being a medicine in India the drug becomes a food supplement in France. In this context, this shift in category (and meaning) is consubstantial to transnational mobility (Pordié 2008: 12). People experience translocality and transformation too when they go across international borders: these changes may bear on their subjectivity (Langford 2002) and on their biology and physiology, subject as they are to transport, jetlag, food intake, medicine, weather and pathogens. Travel and place help produce distinct corporalities: “diverse kinds of travel produce diverse kinds of *re-localized* (i.e. traveling) bodies and biologies,” write Roberts and Scheper-Hughes (2011: 21).

While studying networks is important to understand circulations, examining place highlights the way these networks overlap and collide; the two domains of enquiry should be examined concomitantly. Researching place is also crucial for anthropologists concerned with people’s perceptions, for there is a great deal of practical and emotional attachment to place (Jackson *et al.* 2004). However, in their analytic pursuits, specialists in transnational studies have mainly explored networks (including people, communities, economic enterprises, etc.) and overlooked both place (Gielis 2009) and space (Jackson *et al.* 2004)⁴. The fact that this domain of study has its roots in migration studies and has examined at length people mobility and agency perhaps explains this pitfall. For instance, in their landmark article Alejandro Portes and his colleagues introduced “the individual and his/her support network as the proper unit of analysis” in transnational studies, as “the most viable point of departure” (1999: 220) before delving into more complex stages of enquiry. These methodological assertions do not transpose well to transnational health, as in the

³ For James Clifford, this situation makes location “an itinerary rather than a bounded site – a series of encounters and translations” (1997: 11).

⁴ On the articulation between place and space in transnational settings, see, for example, Yoshihara (2010).

case of medical travel or the circulation and transformation of therapeutic knowledge, quite on the contrary. In order to understand the fabric of transnationalism in these situations, I propose to start by examining the conjunction of locations and space, the way they are socially, culturally and materially produced, transformed and inhabited, by what, by who, and for how long. We should look at processes.

Let us take the case of a high standard wellness center in Southern India, where almost all of the clients are foreigners. None of them reside locally and the average stay within the spa premises amounts for a couple of hours. However, they circulate in a transnational space that includes the wellness center as the nodal point of several networks. What actually bring stability to this space are the Indians. Although some may come from national states located hundreds of miles away to seize a job opportunity, once at work they become immobile, stabilizing agents. These agents (management, therapists, cleaners, gardeners, accountants) form the backbone of the transnational space; they largely allow for its functioning and sustainability. In this case, the suggested unit of analysis is the space itself, and everything that makes it – from the geographically immobile people, institutions, objects and technologies to the international clients and their means of mobility (such as cars, airplanes and credit cards). While the dialectical interaction between national territory and transnational space must of course be acknowledged and closely examined (Robinson 1998), the significance of the local in transnational phenomenon here is exemplary, as it is in general in the medical travel industry: it is a national construct with cross-border appeal and global aspirations, as shown by the case studies of Malaysia (Toyota *et al.*, this issue) and Thailand (Bochaton: this issue; Wilson 2011). Indeed, “the nation-state continues to play a key role in defining the terms in which transnational processes are played out” (Jackson *et al.* 2004: 4). These considerations together form an invitation to turn upside down Arjun Appadurai’s notion of the production of locality in global flows (1996) and stress instead the local production of transnationality.

To be effective and operational, the transnational health space must of course be embedded in networks that extend beyond international borders and must comprise circuits (which may involve new territorial arrangements) that converge within definite places such as hospitals and clinics. Such places are situated contexts which specify transnational activities⁵. These regions and these networks both result from and produce specific “global assemblages” (Ong/Collier 2005), which crystallize in a particular place and at a particular moment in time. This does not preclude the fact that these socio-material and technological assemblages are fluid⁶; they may change patterns and content, while at the same time being prone to a relative time- and space-bound stability, however precarious it might be. This merging of regions and networks, mobile and immobile agents, technologies and materials plays an instrumental role in the making of transnationalism.

Spaces of connectivity

A network is qualified by both circulations and connectivity, each of which present different problems. Circulations are plural in form; the nature of the circuits they follow varies according to what circulates and where it goes to and comes from. Thus, ayurvedic drugs follow different circuits than siddha medical knowledge, Cambodian pepper, or Japanese mangas. The same heterogeneity applies to connectivity. Of particular interest for this paper is that connectivity happens and intensifies in specific spaces that result from the crystallization evoked above, whether it is a hospital, a cyberspace, a teaching center or a multilateral health institution. These are ‘spaces of connectivity’. These spaces allow transnationalism to actually take *place*.

They may take various shapes. In the case of distance education (Sieler, this issue), connectivity is exercised in cyberspace. Siddha therapeutic knowledge is transmitted from India through the internet to international students located anywhere in the

⁵ On the ways migrant transnational practices are, in practice, relatively contained and limited to specific contexts, see Gielis (2009).

⁶ I refer to the notion of fluid as given by Mol and Law (1994).

world. It is a form of transnationalism where all human actors are geographically immobile; none of them embody the transnational the way a migrant would do, but all have the possibility to extend into other places and other times through their virtual modes of communication. There is an “in-betweenness of social practices linking different local contexts, but not strictly reducible to any of them” (Boccagni 2012: 120). Here virtual contacts within a virtual space – which comprises concrete people and things, such as the teacher, his house, the students and their place, computers, satellites, snail mail, etc. – take a tangible form in transnational knowledge transmission, in the granting of certificates and ultimately, in newly acquired therapeutic practice. Elsewhere in Thailand, connectivity in the space in question culminates in a clinic or a classroom where international students learn the basics of Thai massage (Iida, this issue). Once established and stabilized, the space of connectivity fosters these (transnational) exchanges. In these cases, these spaces and the exchanges that take place within them contribute to the production of therapeutic knowledge and practices⁷: siddha medicine is adjusted and transformed *in order to* be trans-nationalized (by withdrawing sensory experiences and oral knowledge); Thai massage is transformed *through* relationships involving Thais and foreigners (by making it a holistic practice in tune with global expectations reflecting trends in complementary and alternative medicine).⁸ These forms of transnational productions involve creativity and imagination – a social practice characteristic of globalization (Appadurai 1996). In each of these cases, however, the imagination is not only affected by the desires of those at great social, cultural and geographic distance, but also by linkages in the form of contacts, discussions and interactions between individuals and across the borders of nation-states – be it through the internet, repeated phone calls, therapeutic interventions or teachings in a classroom. As shown in the articles by Sieler and Iida, these transnational relationships also offer a

⁷ For other examples on the transnational production of medical knowledge and practice, see Pordié (2011a,b) and Zhang (2009).

⁸ The distinction made between the transformation of therapeutic knowledge and practice *prior to* international diffusion and *through* transnational exchanges may appear to be overly clear cut. In practice, these are trends, sometimes simply intentions, and in the former case further transformation occurs when the knowledge, practice or product has reached the global arena, just as transformation through transnational relations does not preclude the fact that change may have taken place, deliberately or not, before diffusion.

grid from which to read “the cultural specificities of global processes” (Ong 1999). (Medical) culture is reorganized across space and time, and contributes to the formation of new, “translocal cultures” (Clifford 1997; Gupta/Ferguson 1992).

This is not to say that the space of connectivity is stabilized forever. In fact, all attempts are made to increase the level of connectivity in a particular transnational health space with the aim of promoting commercial development. Examples abound. One evident situation is branding and marketing in the medical and wellness travel industry (Crooks *et al.* 2011; Pordié 2011a). “The biggest hurdle that medical tourism has had to face, and continues to face, is the challenge of convincing distant potential visitors that medical care in relatively poor countries is comparable with that available at home, in outcome and safety (...) This has been especially so when medical care systems, in countries such as India, have been conventionally regarded in the west as inadequate, ‘even’ for India itself” (Connel 2006: 1094). A variety of strategies has been deployed to counter this perception in most Asian countries, from drafting and implementing specific national policies to establishing international accreditations and certifications for health institutions, or from door to door publicity conducted by private firms (see Bochaton in this issue on the Thai marketing strategies in Lao PRD) to international marketing approaches (as exemplified by the pan-Asian study presented by Toyota *et al.* in this issue). In general, medical institutions rely on a growing global awareness of the hospital brand and the reputation of the country (such as Singapore for Indonesian patients) or of the city – for example, hospitals in Bangalore are trading on the city's reputation as “India's silicon valley,” and thus a hub for the knowledge-based service economy and scientific expertise. In other places, the context of medical and wellness tourism is significantly different. Kerala has a well-established tourism industry and is a major center for Ayurvedic tourism. Recently, this has allowed the Indian state to create the brand “Kerala Ayurveda” in an attempt to attract an increasing number of patients/clients. In the wake of the growing popularity of medical travel worldwide, the success of Ayurvedic tourism and the high volumes of tourists who were already coming to India, various cities and states, such as Kerala, have also sought to expand the “biomedical tourism” industry. This has led to collaboration between leading

entrepreneurs and state governments in many places in India as efforts are made to re-brand the country as a global health care destination. Specialized travel agencies (Planet Hospital, IndUSHealth, Taj Medical Group) and guidebooks, as well as medical structures in the West and health insurance companies in Asia and abroad work together to reinforce not only circulations but also and most importantly connectivity. Largely under-researched to date is the role of brokers and intermediaries (see Bochaton, this issue), who are also instrumental in the transnational chain of activities aiming at building spaces of connectivity.⁹

Efforts directed at increasing connectivity have also entailed a profound reorganization and transformation of the medical and wellness infrastructures (Bochaton, this issue). Corporate hospitals have opened specialist accommodation wings, providing rooms equipped with cable television, telephones, sofas, fridges and air-conditioning, modifying the esthetics and functionality of medical space (Evans *et al.* 2009). Ideally, medical travel involves the rapid transfer of people from the airport to the hospital – which, interestingly, often shares some characteristics with new airports lobbies such as cleanliness, impersonality and freezing temperatures – and the provision of foodstuffs from people’s country or place of origin, to make them as comfortable as possible. Some of the leading staff working in “medical tourist wards” have experience working overseas, some are well versed in foreign languages, and they claim to be more aware of cultural considerations. The industry has realized that it needs to adapt and learn from patient responses to inter-cultural differences – and to use this knowledge to minimize cultural difference and practices in the future.

The spaces of connectivity may shift between cultural insulation and immersion. As far as biomedical travel is concerned, people are realizing it is necessary to promote a generic, sanitized, pristine medical environment of international standards and the qualifications, expertise and international experience of doctors. Biomedical travel is therefore based on a principle of “cultural insulation.” Health care

⁹ For a study focused on the intermediaries of medical travel, see Baujard (2012).

professionals are trying to create a globalized, culturally neutral space that will be familiar to all, in order to develop a better connectivity between the visiting patients and the host hospital. Although more research is required on this subject, it is apparent that many medical care seekers do not feel comfortable travelling to another country for treatment, that some have never traveled overseas before, and therefore minimizing cultural difference is extremely important to the success of medical travel ventures. On the Indian subcontinent, such efforts produce what Mark Nichter calls “accessible India”; that is, a place where foreigners and the Diaspora Indians will be keen to visit or return to, without facing what they perceive to be the burden of dirtiness and poverty of the country at large. Biomedical entrepreneurs are increasingly learning to de-couple the word “medical care” from “tourism,” preferring to frame their clients as “international patients”. These international patients may not be interested in the local culture or place, so providers seek to insulate them as much as possible from it, perhaps only offering an optional, one-day trip to a famous and easily accessible temple or monument. Practitioners also appear to prefer to learn and work within the common globalized language and practice of biomedicine, where cultural differences are recognized, and removed. Here, a form of universality through therapeutic practices is sought after to ease connectivity.¹⁰

While local culture is played down in biomedical hospitals, it is emphasised in other forms of therapies. But what kind of “culture” are we speaking about? Ayurveda or Thai massage, for example, is perceived to be based on tradition, heritage and nature and the corresponding centers or clinics are more often than not located in pleasant restorative, nurturing, tropical environments. Interior design, furniture, music and atmosphere are chosen in relation to healing and traditions, and form an integral part of the therapeutic service and experience. In these contexts, the visitor’s ability to learn about the place and interact with the local culture is of significant importance. However, issues of translation are ever present in that the

¹⁰ The quest for universality, as a means to gain legitimacy and credit on the market, also concerns traditional therapies. On the dialectic between the universal significance of a traditional treatment that may be granted by science (through clinical trials) and its cultural embeddedness, see Pordié (2010, 62). More generally, on the way universal knowledge may come into being at particular times and places, see Tsing (2004).

“cultural experience” and place are represented, adapted and translated (such as the teachings manuals in Iida’s article) to meet the needs, demands and expectations of foreigners, including their cultural conceptions of the body, wellness, “traditional medicines”, age or gender.¹¹

The space of connectivity could be fruitfully articulated to the significant implications of architecture for cultural practices associated with health and health care (Gillespie 2002) and more generally, with the notion of therapeutic landscapes (Buzinde/Yarnal 2012; Conrad 2005; English *et al.* 2008; Gesler 1992; Gesler *et al.* 2004, Smith 2005). While these authors emphasize that the natural and material environment (esthetics, architecture, configuration, ornamentation, etc.) combined with social organization, people perceptions or ideas of territoriality have a role to play in the pragmatics or the symbolism of health and healing processes, it may be suggested that the making of a “therapeutic place” also works on the dynamics of relationships, that is, on connectivity.

Transnational encounters and their temporality

We shall now look at the temporal dimension of connectivity. Transnationalism is broadly defined as the *sustained* linkages between people, places or institutions across the borders of nation-states (See, for example, Faist 2010; Vertovec 1999, 2009). These linkages are presented as continued contacts between any of these entities, as is the case with so-called “transnational communities” (Levitt 2001). The individuals concerned live in a social world that includes various places and communities which stretch between two or more nation-states (Vertovec 2010). A different situation is revealed in transnational health. Take a hospital in Malaysia, a reproductive clinic in Singapore, a teaching center in Thailand or an Ayurvedic spa in India. In each of these cases, the linkages between the foreign patient/client/student and her local doctor/therapist/teacher or her host place are certainly intense but relatively short,

¹¹ One would never see an Indian man giving an oil massage to an Indian woman, although this happens with tourists in South India, and, as I have observed, often according to the tourist’s demands.

and very rarely sustained – unless we consider that the presence of past experiences, which include encounters within and beyond the human realm, remain as a form of connection. How true this view might be, it would perhaps push the idea of transnational connections a bit too far for our purpose. From the perspective of the people themselves, their respective social worlds collide but they find themselves quickly unconnected. As said earlier, those actually living in the nodal points of these transnational spaces are the geographically immobile agents, the vast majority of whom never cross international borders. Their community is local, and if they do have interactions with foreigners, the latter are not considered to be part of the local community. The foreigners' ties to locality are limited to ephemeral forms of businesses, intimacies and emotions that involve therapeutic encounters or teacher-student relations. However, this does not disqualify such situations from being defined as transnational, with particular forms of cross-border relations that present, on one side, important resources for welfare – as in the case of Diaspora (Clifford 1997: 256) –, and on the other, valued resources for health, well-being or learning. In fact, proximity and distance, presence and absence do not need to be opposed, but should be understood as manifestations of the ways space and time deploy themselves (Callon/Law 2004).

Let us take some ethnographical examples. Christoph is a German national that needed a hip resurfacing intervention, which is a technique developed as a surgical alternative to total hip replacement. A pro-active man in his mid-forties, Christoph found out that one of the best specialist surgeons was located in a reputed private hospital in Chennai, South India. Aware that the outcome of the operation was dependent on the surgeon's experience (cf. Shimmin *et al.* 2010), the patient was ready to forgo his medical insurance in Germany and to pay the price in order to be operated on by the famous doctor. He entered into contact with the corresponding hospital service in Chennai through the internet, arranged a date for the intervention, managed to obtain a "medical tourist" visa and flew to India – an unknown country to him. In less than a month his connection to the country, the hospital and the

surgeon became a palpable reality.¹² Christoph stayed for nine days in India. He did not see any of the tourists' attractions and spend his last three days in a resort by the beach about an hour from Chennai to indulge himself with some gentle spa treatments and massages. He came back to Germany satisfied but stopped all form of contact with the people he had met in India. This situation is not uncommon. In my experience, it is in matters relating to reproductive health that the interaction between international patients and the local doctors and clinics is the most sustained. This is especially true for those couples seeking a surrogate mother, since most follow the pregnancy from a distance, visit the country at least twice (to establish the contract and to take part in necessary medical tests and interventions and, at the very end, to take the baby), and often keep a link with the surrogate once they are back in their country with the child¹³. On the other end of the health travel spectrum lie the spas and wellness centers. As said above, the linkages there are established for a few hours at the maximum. Elsewhere, students in Thai massage take a few weeks course at most, feeding the transnational classroom with their presence until a new batch comes in. Indeed, from the perspective of the geographically immobile people in either of these health infrastructures, they see an unending series of international people visit their clinic, ward or school, and each new patient, guest, client or student replaces the other. Local people's experience of transnationality takes place within the physical boundaries of their work place, itself located within the national boundaries of their country. However, they do indeed spend most of their days in a transnational space.

What defines the transnational here is *the sum of intermittent connections and bodily co-presence* between (changing, residing or transient) people that belong to different nations and find themselves together at a particular moment in time in a space of connectivity – a transnational space that coalesces in a hospital, in cyberspace or in a

¹² I have chosen this example among many because it shows a case rarely, if at all, described in the literature in "medical tourism", where an international patient seeks healthcare abroad for a different reason than economic value, technological advancement, long waiting lists or lack of insurance. Here it is the perceived quality of the medical practitioner that was sought after. However, this example mirrors the organizational logic of most cases.

¹³ On the new forms of kinship stemming from transnational surrogacy, see the work by Pande (2009).

classroom. This involves temporality. The cross-border linkages do not need to last very long to fall under the purview of transnationalism as long as they are repeated and maintained across time. This understanding of transnationalism follows the criticism expressed by some authors about the disengagement of the social sciences – and of transnational studies for that matter – regarding the role of “distance contacts” such as travel and occasional encounters in holding social life together (Urry 2004). These kinds of contacts are vital forms of transnational exchanges. In our case, it is the space that is transnational, and not necessarily the individuals and objects that make this space. This situation echoes what I have described above for the virtual students of siddha medicine and their virtual connectedness to their teacher. These are firm and concrete transnational relations. The actors make use of technologies that make them present to one another, in an eloquent example of the “time-space compression” (see Harvey 1989; Urry 1995).

The very nature of medical space determines temporality. Therapeutic interventions and medical courses are time constrained. Treatments generally address acute problems and the teachings are adapted and shortened for foreign students. These configurations prevent long term exchanges, although these may happen according to individual preferences and commitment. On the other hand, individual time constraints are balanced by a high turnover of people accessing these spaces of connectivity, therefore allowing for the multiplication and repetition of transnational exchanges. These considerations may be helpful to revise static conceptualization of transnationalism and to expand its epistemological range.¹⁴

Conclusion

Recent critical scholarship in transnational studies has encouraged further elaboration on the reference points of transnational ties (Boccagni 2012). Based on

¹⁴ In the same vein, Philip Crang and his colleagues (2003: 446) have studied “transnational commodity culture” to provide “a particularly productive entry point into [a] wider conceptualization of transnational space. The study of transnational commodity culture widens the field of study to encompass a range of activities, goods, people and ideas that would not qualify as transnational [otherwise]”.

migration studies, the proposition recognizes its own actor-centered view (*ibid.* p. 119). This article took a different route. It introduced the notion of “space of connectivity”, a methodological device, which highlights the crossing points of transnational circuits. Circulations in these circuits converge in specific places, such as a hospital, a wellness center or a (virtual) classroom, where connectivity deepens. However, a locality is not a given; it is *made* through an array of social and cultural relations and perceptions, natural and material arrangements. These places are seen by the actors as a reference point for transnational relations. In other words, studying spaces of connectivity allows us to concentrate on both networks and place: the former helps to unpack the “internal complexity of cross-border social networks” while the latter is useful to understand their “external complexity”; that is, the ways these networks relate to each other (Gielis 2009).

Spaces of connectivity are not fixed entities; their spatial and temporal attributes are fluid and shifting. The spatiality and temporality of transnationalism are manifold. There are cases where all human actors are immobile and enter into a transnational space through ICTs. Technology therefore renders immobility and transnationalism compatible. In other instances, physical encounters do exist but they are limited by distance and costs, the nature of medical practice and the adjustments made to cater to the needs of foreign patients, clients and students. In each of these configurations, circuits and circulations congregate at the networks’ nodal points. Although they are located at the epicenter of transnational forces, these nodal health infrastructures mostly rely on motionless stabilizing agents. In the health field, the non-transnational takes precedence in the making of a transnational space. If the transnational space is sustained by immobile agents who inhabit the sites of coalescence in this space, mobile agents are free to join in, to plug themselves into the right network, follow the circuit and experience transnational connectivity. This is not small thing: those seeking healthcare offer and immerse their body in the space of connectivity in the hope of being taken care of and, for some, possibly cured. The transnational space is there embodied.

References

- Alter, Joseph ed. 2005: *Asian Medicine and Globalization*, Philadelphia: University of Pennsylvania Press.
- Appadurai, Arjun 1996: *Modernity at Large. Cultural Dimensions of Globalization*, Minneapolis: University of Minnesota Press.
- Baujard, Julie 2012 : Intermédiaires du tourisme médical. Les réfugiés afghans de Delhi, in: *Moussons* 19(1), 151-162.
- Boccagni, Paolo 2012: Rethinking transnational studies: Transnational ties and the transnationalism of everyday life, in: *European Journal of Social Theory* 15(1), 117-132.
- Burawoy, Michael 2000: Conclusion. Grounding globalization, in: Michael Burawoy/Joseph A. Blum/Sheba George/Zsuzsa Gille/Teresa Gowan/Lynne Haney/Maren Klawiter/Steven H. Lopez/Seán Ó. Riain/Millie Thayer (eds.): *Global Ethnography. Forces, Connections, and Imaginations in a Postmodern World*, Berkeley: University of California Press.
- Buzinde, Christine/Careen Yarnal 2012: Therapeutic landscapes and postcolonial theory: A theoretical approach to medical tourism, in: *Social Science & Medicine* 74(5), 783-787.
- Callon, Michel/John Law 2004: Absence-presence, circulation, and encountering in complex space, in: *Society & Space* 22, 3-11
- Chee, Heng Leng/Andrea Whittaker 2010: Introduction: Why is medical travel of concern to global social policy?, in: Special Issue of *Global Social Policy* 10(3), 287-291.
- Clifford, James 1997: *Routes. Travel and Translation in the Late Twentieth Century*, Cambridge, MA: Harvard University Press.
- Cognet, Marguerite/ Anne-Cécile Hoyez/Christian Poiret, eds. 2012 : Expériences de la santé en migration, Special Issue of *Revue Européenne des Migrations Internationales* 28(2).

- Connell, John 2006: Medical tourism: Sea, sun, sand and ... surgery, in: *Tourism Management* 27: 1093-1100.
- Conradson, David 2005: Landscape, care and the relational self: Therapeutic encounters in rural England, in: *Heath & Place* 11(4), 337-348.
- Crang, Philip/Claire Dwyer/Peter Jackson 2003: Transnationalism and the spaces of commodity culture, *Progress in Human Geography* 27(4): 438-456.
- Crooks, Valerie A./Leigh Turner/Jeremy Snyder/Rory Johnston/Paul Kingsbury 2011: Promoting medical tourism to India: Messages, images, and the marketing of international patient travel, in: *Social Science and Medicine* 72: 726-32.
- Digby, Anne/Waltraud Ernst/Projit B. Mukharji eds. 2010: *Crossing Colonial Historiographies. Histories of Colonial and Indigenous Medicines in Transnational Perspectives*, Newcastle: Cambridge Scholars Publishing.
- Dilger, Hansjörg/Abdoulaye Kane/Stacey A. Langwick eds. 2012: *Medicine, Mobility and Power in Global Africa. Transnational Health and Healing*, Bloomington: Indiana University Press.
- Elliott, Susan J/Joan Gillie 1998: Moving experiences: a qualitative analysis of health and migration, in: *Heath & Place* 4(4), 327-339.
- English, Jennifer/Kathi Wilson/Sue Keller-Olaman 2008: Health, healing and recovery: Therapeutic landscapes and the everyday life of breast cancer survivors, in: *Social Science & Medicine* 67(1), 68-78.
- Evans, Jeffrey 1987: Introduction: Migration and Health, in: Special Issue of *International Migration Review* 21(3), v-xiv.
- Evans, Jeffrey/Valerie A. Crooks/ Paul Kingsbury 2009: Theoretical injections: on the therapeutic aesthetics of medical spaces, *Social Science & Medicine* 69(5), 716-721.

- Faist, Thomas 2010: Towards transnational studies: world theories, transnationalisation and changing institutions, in: *Journal of Ethnic and Migration Studies* 36(10), 1665-1687.
- Gesler, Wil 1992: Therapeutic landscapes: medical issues in light of the new cultural geography, in: *Social Science & Medicine* 34(7), 735-746.
- Gesler, Wil/Morag Bell/Sarah Curtis/Phil Hubbard/Susan Francis 2004: Therapy by design: evaluating the UK hospital building program, in: *Health & Place* 10(2): 117-128.
- Gielis, Ruben 2009: A global sense of migrant places: toward a place perspective in the study of migrant transnationalism, in: *Global Networks* 9(2), 271-287.
- Gillespie, Rosemary 2002: Architecture and power: a family planning clinic as a case study, in: *Health & Place* 8(3), 211-220.
- Gupta, Akhil/James Ferguson 1992: Beyond "culture": Space, identity and the politics of difference, in: *Cultural Anthropology* 7(1), 6-23.
- Harvey, David 1990: *The Condition of Postmodernity. An Enquiry into the Origins of Cultural Change*, Oxford: Wiley-Blackwell.
- Hodges, Jill R./Leigh Turner/Ann Marie Kimball, eds. 2012: *Risks and Challenges in Medical Tourism. Understanding the Global Market for Health Services*, Santa Barbara: Praeger.
- Jackson, Peter/Philip Crang/Claire Dwyer 2004: The spaces of transnationality, in Jackson, Peter/Philip Crang/Claire Dwyer (eds.): *Transnational Spaces*, London/New York: Routledge.
- Knecht, Michi/Stefan Beck/Maren Klotz 2012: *Reproductive Technologies as Global Form: Ethnographies of Knowledge, Practices, and Transnational Encounters*, Frankfurt/New York: Campus Verlag.
- Langford, Jean 2002: *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*, Durham, NC: Duke University Press.
- Law, John 2005: And if the global were small and noncoherent? Method, complexity, and the baroque, in: *Society & Space* 22, 13-26.

- Levit, Peggy 2001: *The Transnational Villagers*, Berkeley: University of California Press.
- Mol, Annemarie/John Law 1994: Regions, networks and fluids: Anemia and social topology, in: *Social Studies of Science* 24(4), 641-671.
- Naraindas, Harish/Cristiana Bastos 2011: Healing holidays? Itinerant patients, therapeutic locales and the quest for health, Special Issue of *Anthropology & Medicine* 18(1).
- Ong, Aihwa 1999: *Flexible Citizenship. The Cultural Logic of Transnationality*, Durham, NC: Duke University Press.
- Ong, Aihwa/Stephen J. Collier 2005: Global assemblages, anthropological problems, in: Ong Aihwa/ Stephen J. Collier (eds.): *Global Assemblages. Technology, Politics and Ethics as Anthropological Problems*, Malden, MA: Blackwell.
- Pande, Amrita 2009: "It may be her eggs but it's my blood": Surrogates and everyday forms of kinship in India, in: *Qualitative Sociology* 32(4), 379-397.
- Petryna, Adriana 2009: *When Experiments Travel: Clinical Trials and the Global Search for Human Subjects*, Princeton: Princeton University Press.
- Pordié, Laurent 2008: Tibetan medicine today. Neo-traditionalism as an analytical lens and a political tool, in: Pordié Laurent (ed.): *Tibetan Medicine in the Contemporary World. Global Politics of Medical Knowledge and Practice*, London/New York: Routledge.
- Pordié, Laurent 2010: The politics of therapeutic evaluation in Asian medicine, in: *Economic & Political Weekly* XLV(18), 57-64.
- Pordié, Laurent 2011a: Se démarquer dans l'industrie du bien-être. Transnationalisme, innovation et indianité, in: *Anthropologie & Santé* 3 (url : <http://anthropologiesante.revues.org/805>).
- Pordié, Laurent 2011b : Accentuations et pragmatisme. Le savoir médical tibétain à destination des étrangers, in : *Revue d'Anthropologie des Connaissances* 5(1), 99-130.

- Portes, Alejandro/Luis E. Guarnizo/ Patricia Landolt 1999: The study of transnationalism. Pitfalls and promises of an emergent research field, in: *Ethnic and Racial Studies* 22(2), 217-237.
- Roberts, Elizabeth F.S./Nancy Scheper-Hughes eds. 2011: Medical migrations, Special Issue of *Body & Society* 17(1).
- Robinson, William 1998: Beyond nation-state paradigms: Globalization, sociology, and the challenge of transnational studies, in: *Sociological Forum* 13(4), 561-595.
- Gielis, Ruben 2009: A global sense of migrant places: toward a place perspective in the study of migrant transnationalism, in: *Global Networks* 9(2), 271-287.
- Sassen, Saskia 2004: Local actors in global politics, in: *Current Sociology* 52(4), 649-670.
- Sheller, Mimi/John Urry 2006: The new mobilities paradigm, in: *Environment and Planning A* 38(2), 207-226.
- Shimmin, Andrew J./Steven Graves/Philip C. Noble 2010: The Effect of Operative Volume on the Outcome of Hip Resurfacing, in: *The Journal of Arthroplasty* 25(3), e4.
- Smith, Fiona 2005: Medical geography: therapeutic places, spaces and networks, *Progress in Human Geography* 29(4), 488-495.
- Smith-Morris, Carolyn/Lenore Manderson/Elizabeth Cartwright 2010: Introduction. Patients without Borders: Understanding Medical Travel, in: Special Issue of *Medical Anthropology* 29(4), 336-343.
- Stilwell, Barbara/Khassoum Diallo/Pascal Zurn/Mario R Dal Poz/Orvill Adams/James Buchan 2003: Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges, in: *Human Resources for Health* 1(8), doi:10.1186/1478-4491-1-8.
- Tsing, Anna Lowenhaupt 2004: *Friction. An Ethnography of Global Connection*, Princeton: Princeton University Press.
- Urry, John 1995: *Consuming Places*, London/NewYork: Routledge.
- Urry, John 2004: Connections, in: *Society & Space* 22, 27-37.

- Vertovec, Steven 1999: Conceiving and researching transnationalism, in: *Ethnic and Racial Studies* 22(2), 447-462.
- Vertovec, Steven 2009: *Transnationalism*, New York/London, Routledge.
- Vertovec, Steven 2010: Transnationalism and identity, in: *Journal of Ethnic and Migration Studies* 27(4), 573-582.
- Wilson, Ara 2011: Foreign bodies and national scales: Medical tourism in Thailand, in: *Body & Society* 17 (2&3), 121-137.
- Yoshihara, Naoki 2010: *The fluidity of place. Globalization and the Transformation of Urban Space*, Victoria: Trans Pacific Press.
- Zhan, Mei 2009: *Other-Worldly: Making Chinese Medicine through Transnational Frames*, Durham, NC: Duke University Press.
- Zimmerman, Cathy/Ligia Kiss/Mazeda Hossain 2011: Migration and health: A framework for 21st century policy-making, in: *PLOS Medicine* (Migration & Health Collection) 8(5), e1001034. doi:10.1371/journal.pmed.1001034.

Global track, national vehicle:
Transnationalism in medical tourism in Asia

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In this paper, we use the notion of “transnational space” to locate the reconfiguration of healthcare services in the medical tourism industry in Asia. We explore how the transnational space is constituted by a range of actors – hospital corporations, medical professionals, intermediaries, and consumers, and how healthcare services are being reconfigured in this space. In particular, we pay attention to the roles of national governments in developing the industry, including their promotion of the “national brand” as a marketing strategy. By using the “transnational” framework we wish to move attention away from the metaphorical “global market” which implicitly assumes that a homogenous and universalizing market force is behind the development of the medical tourism industry. We argue that the development of medical tourism is purposefully initiated and conditioned by various local actors. Our paper calls attention to the more concrete, politically, historically and geographically specific transnational processes. We will draw on our longstanding work on Malaysia primarily, but also on Singapore, Thailand, and Japan, to illustrate our argument.

Medical tourism, generally understood as the international travel to utilize medical services, emerged globally as a major growth industry at the dawn of the new millennium (Connell 2006, Turner 2007, Hopkins *et al.* 2010). It is arguably a time-honoured phenomenon that individuals travel internationally to receive health care, but medical tourism as we witness today is qualitatively different. Not only that the number of people involved is unprecedentedly larger and rapidly growing, but more importantly cross-border mobility for medical treatment is being developed into an industry in its own right. The medical tourist industry encompasses not only patients and healthcare professionals, but also facilitators, intermediaries, and marketing agents. International associations have been established, conferences convened, government programmes to promote medical tourism promulgated.¹⁵ An additional testimony to the consolidation of medical tourism is the plethora of websites catering to the potential medical tourist, guidebooks for the consumers,¹⁶ and business reports for policy makers and investors.¹⁷

The term “medical tourism” can be problematic as it lumps together highly diverse types of cross-border healthcare utilization – ranging from routine medical screening and simple outpatient procedures such as cataract treatment, to cosmetic surgery, fertility treatments, elective surgery such as hip replacements, organ transplants, cancer treatment and heart surgery – under the rubric of “tourism” with the connotation of enjoyment and leisure (Kangas 2010, Whittaker 2008). While fully recognizing this rich diversity of medical travel, our paper retains the terms medical tourism and medical tourist industry to refer to “loosely institutionalized assemblage” (Wilson 2011) precisely because the terms are used by the various stake

¹⁵ In the Asian region, the First International Medical Travel Conference (IMTC) was held in Singapore from 12-15 December 2006, followed by at least one each subsequent year in the Southeast Asian region. The International Medical Travel Association was spawned from the first IMTC (“Manila hosts 2nd International Medical Travel Conference” in: *Arab News*, 10 October 2007). In the United States, the inaugural meeting for the International Medical Tourism Association (MTA) was held at the Second Annual International Medical Tourism Conference, held at Washington DC, 3-5 December 2007 (“Historic medical tourism conference at consumer health world” in: *Business Wire*, 12 September 2007).

¹⁶ For example Woodman’s (2008) guidebook *Patients Beyond Borders* has now been adapted for a number of countries.

¹⁷ Examples include Herrick (2007), RNCOS (2007), and Youngman (2008).

holders including the national governments in Asia. The (mis)usage of the terms is an indication of the institutionalization of medical travel. As our paper is about how such an industry is created institutionally rather than about medical travel per se, it is more appropriate to use the terms as adopted by the players in the industry.

While any cross-border movement is potentially a transnational phenomenon, the processes that we witness in the case of medical tourism – the development of both physical and institutional infrastructure, the involvement of multiple players with clearly defined roles, and the emergence of norms and expectations with regards to conduct and practice – are essential for constituting a meaningful “transnational space” or “field”. Existing literature on transnationalism has conceptualized transnational social field in relatively broad terms. For instance Peggy Levitt and Nina Glick Schiller define it as “a set of multiple interlocking networks of social relationships through which ideas, practices, and resources are unequally exchanged, organized and transformed” (Levitt and Schiller 2004: 1009). Some scholars attempted to broaden the scope even further. For instance, by removing the word “social”, others proposed a visioning of transnational space to accommodate not only people but also activities, goods, and ideas. Peter Jackson and his colleagues (2004: 16) draw from their research on British South Asian transnational commodity culture¹⁸ in relation to food and fashion, to trace the global flows of specific commodities and cultural styles through commodity circuits and complex networks (rather than vertical commodity chains). Such transnational space is thus multi-dimensional and multiply inhabited by a range of producers, consumers and intermediaries who “have varying investments in, experiences of and expressions of transnationalism” (Cragg *et al.* 2003: 449) Such broad conceptions of transnational field are useful for our study since medical tourism as a field is decidedly multifaceted. As we will demonstrate throughout this article, many immobile agents, be they people, things or institutions, are often more important than the mobile ones

¹⁸ Understanding commodities as constitutive of social relations, cultural identity and economic power, transnational commodity culture refers to the ways in which commodities are constituted transnationally, with producers, consumers and intermediaries actively reworking their meanings in different cultural contexts as the goods are manufactured and moved around the world (Jackson *et al.* 2004: 16.)

in constructing the transnational field. But this broad definition is not without drawbacks. The broad concept brings about the danger of blunting its analytical sharpness. If everything that is cross-border is considered part of transnational fields, what then would be worthy of critical attention? By what means can we assess the historical and structural changes? How do we discern the policy implications?

This article, by focusing on medical tourism in Asia, seeks to deepen our understanding of transnationalism. We demonstrate that medical tourism in Asia is inherently transnational (domestic travel for medical care is not considered as part of medical tourism the way that domestic tourism is part of tourism), bears a series of “global” characteristics (e.g. the adoption of international accreditation), but it is at the same time a complexly structured landscape instead of a level ground or flat space. As a transnational field, medical tourism in Asia does not emerge from ever-expansive networks from outside and from above that defy national borders and state sovereignty, but is constituted by various firmly located players, particularly the national governments. The national and local players adopt history-specific and context-specific strategies to pursue their global aspirations.

A number of scholars have recently made similar efforts to bring in institutionalist analysis to the study of medical tourism. Nicola Yeates (2011: 1110) for instance argues that the framework of transnationalization is particularly constructed as it combines “structural understandings of global power relations with an emphasis on social interactions between defined actors in ways that keep sight of human agency, impacts upon material welfare and wider social development.” She points out that consumer-based care migration – medical tourism being the primary case – has not received as much scholarly attention as for example producer-based (professional) migration. Situating the analysis in a receiving country, Ara Wilson (2011: 134) in another example, convincingly argues that medical tourism in Thailand is a national assemblage that has developed from pre-existing local conditions, evoked national symbols and institutions, and been successfully produced as a national project in the context of “global realignments of bodies, nations, capital and medicine”.

In this paper, we question whether such global realignments can be seen as a given context. Instead we view the globality of medical tourism as a project that is constantly in the making by local actors. We focus on the transnational and global dimensions of medical tourism; but rather than elevate them as the overarching condition, we disentangle them as projects that are being developed by multiple actors.

In what follows, we will first highlight a distinct challenge that medical tourism poses as a research subject, that is the distancing of highly embodied practices, and the transnationalization of processes that are deeply embedded in nation states. We suggest that a regional focus, comparative method and institutional analysis will help in addressing this challenge. We will then review how medical tourism in Asia has grown from national strategies in dealing with the global economy. This is followed by two sections on specific strategies taken by various Asian countries. The first set of strategies aim at enjoining the practice of healthcare to the established global system by such means as accreditation and marketing. The second aim at encouraging inflows of patients and actualizing care provision. While the former create general infrastructure and potentiality for the industry, the latter actualize them. We liken the first set of strategies to building a track, and the second to steering a vehicle. The track must be built according to global standards, while the vehicle has to be maneuvered according to local conditions.

The paper derives from our long term research started in 2003. Our main methods include in-depth interviews, documentary study and participatory observation in hospitals and promotion events. The material that is immediately related to this article was collected in Chee's interviews with management personnel at four leading private hospitals in Penang, Malaysia in July 2007, and again in October 2011 (Hospital A, B, C and D), field visits to two hospitals in Kuala Lumpur in February 2008, Toyota and Xiang's interviews with hospital personnel in the Philippines, Thailand and Singapore in September 2007. The authors also attended the Medical Travel World Congress 2008 in Kuala Lumpur, and the Global Healthcare Congress 2009 in Singapore. The hospitals in our study cannot be named due to an

undertaking of confidentiality.

The intimate goes global: Medical tourism as a new industry

Based on data from World Tourism Organization (WTO), Percival Carrera and John Bridges (2006) estimated that there were 154.25 million “medical tourists” who spent between US\$128.25 and 256.5 billion in medical tourism annually in the mid-2000s.¹⁹ In 2004, the consultancy McKinsey estimated a worldwide medical tourism market of US\$40 billion (cited in Herrick 2007: 1). This hardly seems commensurate with the attention that has been given to the industry, but the smallness belies its rapid rate of growth. In 2008, Deloitte (2008), another industry consultancy, estimated that worldwide medical tourism expenditure had risen to US\$60 billion. If these two estimates are comparable, it would mean that the market has grown by 50 per cent in four years, or 12.5 per cent per year.

Medical tourism is often construed as a global phenomenon resulting from globalizing forces. First, medical tourism is commonly thought of in terms of patients travelling from developed countries to developing countries to take advantage of lower priced medical care or to circumvent long waiting lists in their home countries (Yeates 2011: 1116; Crooks *et al.* 2011). The “global medical marketplace” is thought of as a universal market that is determined by a demand-supply relation. Medical tourism is also examined as a form of international trade. From the early 1990s the United Nations defined medical travel as Mode 2 of six modes of international trade (Diaz and Hurtado 1994; Zarrilli and Kinnon 1998). A body of literature also analyzed the possibly negative impacts of the globality, for instance its draining away local health resources and the lack of access to legal recourse in cases of malpractice (See for example Carrera and Bridges 2006; Turner 2007; Pennings 2007;

¹⁹ Carrera and Bridges (2006) also estimated that there were 617 million “health tourists” who spent US\$513 billion worldwide annually. Medical tourism should be distinguished from “health tourism”. “Health tourism” first appeared in the academic literature of tourism studies describing a deliberate marketing strategy on the part of a tourist destination or facility to attract tourists by specifically promoting health services and facilities that could range from spas, special diets and thermal swimming pools to medical check-ups and minor surgery (Goodrich and Goodrich 1987). By comparison, medical tourism specifically involves medical examination and treatment.

Crozier and Baylis 2010; Hazarika 2010).

Globality is indeed a crucial dimension, or even precondition, of medical tourism. To begin with, biomedicine as a body of knowledge and sets of technical practice is supposedly universal, and medical care is increasingly standardized and homogenized. Furthermore, the hospitals which are targeting the medical tourist market could be owned by transnational corporations, within which there is a corporate logic behind a push towards standardizing and homogenizing. Many of the private hospitals in Asia that cater to medical tourists are owned by transnational corporations. The large corporations own chains of hospitals across the region. For example, one of the largest hospital corporation in Asia now is Parkway Holdings, which is majority owned by Khazanah, Malaysia's sovereign wealth fund, but it started off as a Singapore company and was at one time majority owned by Newbridge, a United States private equity fund. Parkway Holdings owns 11 hospitals in Malaysia, four in Singapore, two in India, and one each in Brunei and the UAE.²⁰ Other examples are Columbia Asia which owns seven hospitals in Malaysia, six hospitals and one clinic in India, and hospitals in Vietnam and Indonesia;²¹ and HMI, a Singaporean public-listed company, which is majority shareholder of two premier medical tourist hospitals in Malaysia.

Nevertheless, medical care is not a product commodity; but constitutes a highly sensitive and even intimate service that directly acts on human bodies and can be a life and death matter. People commonly make choices in healthcare based on local knowledge, doctor's referrals and word-of-mouth recommendations. Our interviews strongly suggest that cultural familiarity, general perception about the destination country, patients' previous experiences, and trust all play very important roles in patients' decision making on where to go for what treatment. All of these factors are hard to quantify. Apart from individuals' embodied experiences, medical care as practices cannot be truly "globalized" as they are deeply embedded in national and local systems of financing and welfare provision. Particular medical care

²⁰ Parkway Holdings website, <http://www.parkwaypanantai.com/>, accessed 21 November 2010.

²¹ Columbia Asia website <http://www.columbiaasia.com/>, accessed 21 November 2010.

arrangements are regarded as defining features for nation-states. Each country has developed its medical care system and infrastructure in particular ways following specific historical trajectories.

Research has also pointed out that medical tourism does not necessarily operate like a flat global market determined by a universalistic pricing mechanism. Valerie Crooks *et al.* (2011) showed that price was hardly featured in marketing brochures despite the widespread belief that lower cost was a primary motivation for medical tourists. Furthermore, medical tourism is characterized by strong regionalism. The 2005 study by Carrera and Bridges (2006) points out that the largest flows are within the developed world. Asia Pacific stands out as the second most popular destination (excluding the Americas) after Europe, with 19.5 per cent share of the medical tourism market in 2005.

In Asia, the major medical tourism flows are intra-regional, i.e. within Asia, rather than from Europe or America. Furthermore, each region has its own distinct characteristics. In Asia for instance, many patients travel from a poorer country to a richer one to access better quality care (Nomura Asia Healthcare Research Team 2009, 46). The upper middle classes from Indonesia and Malaysia have been utilizing Singapore's medical centres since the 1980s. Japan is now actively planning high-end medical treatment programmes catering for patients from developing countries in the region especially China. This is obviously very different from the commonly held image that patients from high-income countries seek treatment in low-income countries driven by price.

How can we tackle the global dimension of medical tourism without assuming that abstract, universal, externally imposed global forces dictate developments on the ground? Conversely, how can we appreciate the diversities, specificities and grounded negotiations without losing sight of their emergent global consequences? In this regard, we suggest that a regional scope, institutional analysis and cross-country comparison can be productive. Such a protocol of methods enable closer

examination of the historically conditioned, context-specific, yet inter-related, measures adopted by different countries which collectively contribute to the emergence of medical tourism as a general phenomenon. We will now shift our focus to Asia and review how medical tourism developed there historically through the interaction between national and global developments.

Globalization as a problem, globalization as a solution: Historical development of medical tourism in Asia

The development of medical tourism in Asia is not even. In the late 1990s and early 2000s, the forerunners were Singapore, Thailand and Malaysia, and more recently India (Deloitte 2008). The latecomers include the Philippines, South Korea, Taiwan and Japan. Medical tourism in Asia should first of all be attributed to economic liberalization in the 1980s and 1990s that encouraged the rapid growth of private hospitals (Wilson 2011; Sengupta 2011; Chee 2010). In Singapore, the government had envisioned the country as a regional medical centre attracting patients from neighbouring countries, and in this regard, had encouraged the growth of private and specialist medical services from as early as 1986 (Purcal 1989; Phua 1991). In Malaysia, the emergence of medical tourism was preceded by three decades of rapid growth of private hospitals and a policy of corporatization and privatization. The few private hospitals set up in the 1970s by groups of physicians were bought up by large corporations, or were themselves transformed into corporations. Since the 1970s, the private sector has outstripped the public sector in providing certain specialist services. For example, over 70 per cent of the specialist services in radiotherapy, magnetic resonance imaging, CT scanning, mammography, and cardio-thoracic treatment over the years 1999-2001 were in the private sector.²²

The Asian financial crisis in 1997 stood out as a turning point. Following the rapid devaluation of the Thai baht in July 1997, the Malaysian ringgit also dropped rapidly. This not only affected purchasing power for healthcare and employer health benefits, thereby causing utilization rates in private hospitals to drop, but also caused the

²² Personal communication with an officer in the Ministry of Health in 2003.

prices of imported pharmaceuticals, medical supplies, and medical equipment to soar (UNDP and ANU 1998). In the prevailing economic climate then, private hospitals could not increase prices, and therefore, their operating margins and profits were badly affected. In Thailand, the crisis made it evident that the high-end private hospitals had an over-capacity of 300 per cent (Rabobank International Asia Pacific 1999). When the financial sector crashed, the private hospitals were servicing loans that were denominated in foreign currency, and therefore incurred large losses, requiring debt-restructuring in order to survive. Bumrungrad Hospital, for example, was one such hospital that was badly affected by the crisis. The devaluation of the baht, on the other hand, provided the opportunity for the hospital to attract overseas patients on the basis of the relatively lower charges. Patient load increased rapidly after 1997, with a large influx of foreign patients. By 2003, foreign patients made up more than a third of its total patients and accounted for 41 per cent of its revenue.²³

Singapore's financial sector and currency were not badly affected by the Asian financial crisis, and domestic financing for health care remained largely intact. However, the financial crisis affected its major medical tourist source countries, Indonesia and Malaysia. As a result, foreign patients in Singapore fell by more than a third between 1997 and 1998 (Khoo 2003). The sharp drop in overseas patients together with a shift to public hospitals by local patients resulted in a contraction in occupancy rates from over 70 per cent to 55 per cent, providing a strong motivation for private hospitals to diversify their source countries (Rabobank International Asia Pacific 1999, 26). Thus, instead of retreating from globalization, nation-states in Asia actively sought new global solutions, and expansion of medical tourism became an important measure to address the problem of overcapacity and failing profit in the private medical care sector (Toyota 2012).

Joining the global track

²³ *The Straits Times* 19 March 2005: Sick? Get some five-star treatment. See also UOB Kay Hian Securities Co., Ltd. 11 March 2004: Thailand: Bumrungrad Hospital: A premier hospital with growth potential, Thailand: UOB Kay Hian Securities.

The specific ways of how medical tourism in Asia has been developed should also be understood through the dialectics between the national and the global. First of all, in most of the Asian countries, nation states play the central role. In Thailand, the main state actors are the Tourist Authority of Thailand, the Export Promotion Board and the Public Health Ministry, while the businesses have formed a Medical Tourism Cluster to act in unison. In Malaysia, the Ministry of Health (MOH) is the main state player, while the Association of Private Hospitals (APHM) has dominated in advocacy and public discourse. In 2009, the Malaysia Healthcare Travel Council comprising both government and business sectors was established to coordinate efforts. In Singapore, the main coordinating body is Singapore Medicine, made up of the Singapore Tourism Board, Ministry of Health, and two other government agencies.

In developing medical tourism, governments and hospitals have actively sought to join the established global track. The specific measures include adopting the mainstream international accreditation standards, packaging medical care into tradable commodities, and liberalizing advertisement regulations in order to further marketize care. We shall address these three strategies individually below.

Accreditation

The accreditation process standardizes procedures and makes medical care universally comparable. The Joint Commission International (JCI) accreditation is the dominant standard bearer. JCI is an affiliate of the Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations, a not-for-profit organization developed in the United States to accredit health care organisations and programmes. It was reported that 11 hospitals and three medical centres in Singapore have attained JCI accreditation²⁴, while Bumrungrad International, one of the leading medical tourism hospitals in Thailand, proudly claims to have been the

²⁴ Singapore Medicine, <http://www.singaporemedicine.com/index.asp> (accessed 20 November 2010).

first Asian hospital to attain JCI accreditation in 2002.²⁵

Malaysian hospitals initially did not seek JCI accreditation. It was perhaps thought that the sanction of the Ministry of Health (MOH) and the Association of Private Hospitals Malaysia (APHM), which was granted to 35 hospitals selected for official health tourism promotion, would be adequate to reassure potential customers, particularly those outside the country, of the safety and quality of these hospitals.²⁶ Most of these 35 hospitals have the Malaysian Society for Quality in Health (MSQH) accreditation. Introduced in 1997 by the MOH in collaboration with the APHM, the Malaysian Medical Association (MMA), and other medical professional bodies, this is implemented by the MSQH, which is affiliated to the International Society for Quality in Health (ISQua) and overseen by the ISQua Accreditation Council Federation.²⁷ It is therefore an international system based on the federation of national bodies, in contrast to the JCI which is a transnational actor. However, the MSQH accreditation has proven to be insufficient. Thailand and Singapore and then India have overtaken Malaysia in competition, and Malaysian hospitals have finally succumbed to the perceived need to attain the transnational JCI. The first was the Penang Adventist Hospital which received JCI accreditation in November 2007 (for 2008-2010), followed by Prince Court Medical Centre in December 2008, and in 2009, by the Subang Jaya Medical Centre, Pantai Hospital Kuala Lumpur and the National Heart Institute.²⁸ In sum, the global supersedes the national in accreditation.

²⁵ Bumrungrad International Hospital, "First Asian Hospital to get International Accreditation," <http://www.bumrungrad.com/en/about-us/bumrungrad-hospital-accreditation-jci-others> (accessed 22 December, 2011).

²⁶ Association of Private Hospitals Malaysia, <http://www.hospitals-malaysia.org/portal/index.asp> (accessed 20 November 2010). This list may not include all hospitals which have medical tourism objectives, but they include the major ones. The list remained fairly constant except for several name changes due to changes in ownership up until the end of 2010. It has since increased from 35 to 41 hospitals (accessed 22 December 2011).

²⁷ Malaysia Ministry of Health, *Malaysia's Health 2002: Technical Report of the Director-General of Health* (Kuala Lumpur: Malaysia MOH, 2002), 109.

²⁸ JCI, <http://www.jointcommissioninternational.org/> (accessed 20 November 2010).

Packaging

Unlike accreditation, packaging is an exclusively local initiative. The most common packages are various combinations of medical screening tests. One hospital for example offered medical screening packages for executives and children, and also for lasik treatment of the eyes;²⁹ while another offers a golden years program, a maternity package, and a premarital screening profile in addition to an executive health screening program.³⁰ These screening packages are not necessarily exclusive to medical tourism since they are widely purchased by local patients as well.

Another type of packaging is offered jointly by medical tourism companies and hospitals, and is more directly tied to medical tourism. One of the earliest to operate from Penang was *Beautiful Holidays*, started in 2002 by a Dutchwoman who was co-opted to be co-chairman of the Health Tourism Promotion Taskforce of the Penang Tourism Council.³¹ At that time, they teamed up with the Loh Guan Lye Specialist Centre in Penang to offer cosmetic surgery packages. They have maintained a focus on cosmetic surgery, stating on their website that they work with two internationally accredited private hospitals in Penang.³² Another notable example is HSC Medical Centre, which worked with Malaysian Airlines to offer the MAS Golden Holidays-HSC Medical Package, that includes airport transfers and hotel accommodation with its diagnostic packages.³³ HSC also collaborates with Renaissance Hotel and Goldjoy Holidays, a Hong Kong based travel agency. MedRetreat, an American medical tourism company has collaborative ties with at least two of the hospitals that Chee visited during fieldwork in Penang (2007/2010).

²⁹ Island Hospital, <http://www.islandhospital.com/home.html> (accessed 10 November 2010).

³⁰ Gleneagles Penang, "Our Packages," <http://www.gleneagles-penang.com/package/index.htm>, (accessed 22 December 2011).

³¹ *Time Asia* 27 Oct 2003: Sun, sea and scalpels.

³² Beautiful Holidays, <http://beautiful-holidays.com/page.asp?TitleReferenceID=1&LanguagesID=1> (accessed 20 November 2010)

³³ HSC Medical Centre, <http://www.hsc.com.my/eng/home.php?flash=yes> (accessed 20 November 2010). This facility offers ambulatory healthcare, and is not among the 35 hospitals on the MOH-APHM list.

Advertising and marketing

Packaging per se is not sufficient. Packages must be known. Advertisement of medical care is normally subject to stringent controls, but it has been significantly liberalised in order to facilitate the medical tourist industry. In Malaysia, controls were gradually eased over the last few years, with medical practitioners and institutions being allowed to advertise their services from mid-2005 by publishing their names, disciplines, places of practice, credentials, photos, in newspapers, websites and telephone directories, although the information still has to be vetted by the Medicine Advertisements Board.³⁴ Recently, the Minister of Health announced that the Board has further liberalised advertisement guidelines, because the Government wanted to “ensure that Malaysia maintained its competitiveness in attracting health tourists, after seeing countries like China, India and Thailand go all out to advertise their facilities”.³⁵

Hospitals that aim at the medical tourist market have established marketing departments as well as engaged hospital representatives in their target cities abroad. The emphasis on marketing has meant a restructuring of hospital management that is changing the way that medicine is practised; that involves, among other things, the use of third party intermediaries and agents to recruit patient-customers.³⁶ The state-industry nexus plays a big role in marketing through trade missions and exhibitions overseas. For example, the Malaysia External Trade Development Corporation (MATRADE) and Tourism Malaysia, both government agencies, market Malaysia’s health tourism in road shows, marketing promotions, and trade missions and

³⁴ *The Star*, “Doctors can now advertise their services,” 29 November 2002; *The Star*, “Doctors and hospitals can now advertise,” 28 June 2005.

³⁵ *The Star*, “Healthcare providers can now advertise in all mediums,” 23 September 2010; Malaysia Ministry of Health (MOH) Pharmaceutical Services Division, “Advertising Guidelines For Healthcare Facilities And Services (Private Hospitals, Clinics, Radiological Clinics And Medical Laboratories),” available at: http://www.pharmacy.gov.my/aeimages//File/Advertising_Guidelines_Healthcare_Facilities_and_Services.pdf (accessed 20 November 2010).

³⁶ Intermediaries may be independent medical tourism provider companies such as Gorgeous Getaways and Beautiful Holidays, smaller companies in source countries, individual agents who act as sub-contractors, or salaried employees of the hospitals.

exhibitions. Between 2001-2002, MATRADE organized at least three specialised healthcare missions to promote health tourism in the Middle East, Myanmar, Vietnam, and Indonesia (particularly in Jakarta, and Surabaya) (Malaysia Ministry of Health 2003: 108-9.). In some cases, hospitals may also send their own teams or follow the governmental teams. In sum, marketing is a local initiative aimed at global reach that is carried out transnationally.

Steering the national vehicle

Joining the global track creates the potential for transnational flows. But building a road does not automatically bring in traffic, and certainly does not determine who will be driving around, how, and when. The actual flows of medical travelers are incited according to a different logic. In this process national and local specificities or uniqueness, as opposed to globality or universality, become valuable assets.

“Country brands will define hospital brands”

“Country brands will define hospital brands”, as one hospital marketing director puts it. Despite multinational corporations being increasingly important stakeholders in medical tourism, national image is said to be crucial in attracting clients. The Singapore government, for instance, set up Singapore Medicine in charge of marketing for the whole country. They promote the image of Singapore medical tourism that is based on good quality and high technology. The marketing materials highlight “Singapore, Asia’s leading medical hub,” “World-class healthcare you can trust” and “Singapore: More than a world-class health destination” (Singapore Medicine 2005; Woodman 2008).

One guidebook frames Malaysia as “the international medical community’s best-kept secret” (Woodman, 2008: 282–3). Selling primarily on low price, the write-up proclaims, “A dazzling array of tests and exams ... can be had for around US\$500. Malaysian hospitals were the creators of the ‘well-man’ and ‘well-woman’ packages: extensive, low-cost physicals and tests promoting preventive care.” Despite the

government's efforts, private hospitals in Malaysia felt that Malaysian medical tourism lacked an established brand and identity. In order to remedy this, the APHM appointed an advertising agency to come up with a brand for the country's medical tourism industry.³⁷ In 2009, following proposals from the business sector, a new branding effort began with the Health Minister launching a logo and the website 'Malaysia Healthcare'.³⁸

Seven hospitals in Penang have gone one step further. They established the Penang Health Group to jointly market their services to the international market. As the marketing executive in Hospital D explained, within the country, the hospitals may be competitors, but "... outside the country, it is better to do the marketing together, because people remember better".³⁹ According to the Chairman of the group, the group is trying to 'copy' Singapore Medicine⁴⁰, but whereas the latter is governmental, the Penang Health Group is a "pure private venture".⁴¹

"Point-to-point" flows

Even as the rhetoric of medical tourism is to make it global, the actual flows are strongly characterized by intra-regional connections and "point-to-point" mobility that resembles what James Ferguson describes as "global-hopping," instead of "global-covering," processes of globalization (Ferguson 2006: 38, Xiang 2012). Take Thailand as an example. Out of 1.2 million foreign patients in 2009, the top three nationality groups are from Saudi Arabia (44 per cent), Qatar (9 per cent), and Omar (6 per cent), followed by Japan (5 per cent), Burma (5 per cent), the United States and

³⁷ *The New Straits Times*, "Medical tourism revenue seen growing 30 per cent yearly," 10 March 2008.

³⁸ *The Sun*, "Driving healthcare travel," 10 June 2009.

³⁹ Interview by Chee, 11 October 2010.

⁴⁰ Singapore Medicine is described as a multi-agency government-industry partnership, led by the Ministry of Health and supported by three other governmental agencies (Singapore Medicine website, http://www.singaporemedicine.com/abt_us/abt_us1.asp, accessed 21 November 2010). It leads and implements the marketing of medical tourism in Singapore as a whole, i.e. creating the brand 'Singapore'. Singapore medical tourism is considered a strong brand, because it successfully conjures up an image of high technology and high quality healthcare, although it may be more expensive compared to its neighbours.

⁴¹ Interview by Chee, 9 July 2007.

United Kingdom (2.5 per cent each) (Tourism Authority of Thailand 2010). In India, 19 per cent of foreign patients are from Bangladesh, Nepal, and Sri Lanka, 16 per cent from the Middle-East, 9 per cent from Afghanistan, and 18 per cent from Iraq (Tourism Authority of Thailand 2010). These intra-South Asian flows are marked by specific place-to-place flows: from Bangladesh, Nepal and Bhutan to Kolkata, and from Pakistan to New Delhi and Mumbai.

In Singapore and Malaysia, the largest market has been neighbouring Indonesia. Singapore tried to diversify source countries after the 1997 Asian financial crisis, notably by signing MOUs at governmental level with some Middle Eastern countries, including the United Arab Emirates (UAE) and Bahrain.⁴² From 74 per cent in 2000, the proportion of Indonesians dropped to about 50 per cent in 2006, but they were replaced by increasing percentages of patients from Bangladesh and Vietnam, rather than from outside Asia (Nomura Asia Healthcare Research Team 2009: 7).

In Malaysia, over the three years from 2006 to 2008, Indonesians constituted 77 per cent of medical tourists, with much smaller proportions coming from Japan (3.4 per cent), Europe (2.7 per cent), India (1.8 per cent), China (from 1.3 to 1.8 per cent), the Middle East (from 0.5 to 1.0 per cent), and Singapore (1.1 per cent).⁴³ The primary destination is the state of Penang, followed by Melaka, and then the Klang Valley central region.⁴⁴ According to the CEO of Hospital B, 65 per cent of the foreign patients in Malaysia go to Penang, 20 per cent go to Melaka, and the rest go to the Klang Valley.⁴⁵ This is corroborated by an executive in Hospital C, who said that in 2006, fewer than 10 hospitals generated 90 per cent of the volume, and these are

⁴² Free medical care is provided for UAE citizens by the government, which started sending cancer referrals to Singapore in 2002. As many as 70 per cent of UAE's overseas referrals come to Singapore (*The Straits Times*, 15 January 2005). Singapore also has a memorandum of understanding with the Bahrain government (*The Straits Times*, 27 November 2004). Qatar and Kuwait, whose citizens do not require visa to enter Singapore, are also targeted for medical tourism.

⁴³ Malaysian Tourism Promotion Board, *Perangkaan pelawat-pelawat Semenanjung Malaysia* (Visitor statistics), (Kuala Lumpur: MTPB) 2006, 2007, 2008.

⁴⁴ In 2007, 62 per cent of medical tourism gross receipts in the country come from the seven hospitals in the Penang Health Group, and in 2008 it was 56 per cent (calculated from figures released by APHM officials, *The Star*, 14 Feb 2009).

⁴⁵ Interview by Chee, 9 July 2007.

mainly in Penang and Melaka, with very minimal coming from the Klang Valley.⁴⁶

All of the four hospitals where Chee carried out interviews have the majority of their foreign patients from Indonesia, and they also have specific arrangements for Indonesia in staff and marketing. In Hospital C, for example, in 2006, 80 per cent of their foreign patients and 90 per cent of their revenue from foreign patients are from Indonesia. In the words of the general manager, "There are some Americans ... they come for gynae, orthopaedic surgery. ... The Indonesians come for everything. There are seven daily flights from Medan to Penang".⁴⁷ The website of this hospital lists an 'Indonesia Representative Office' with telephone numbers, fax numbers, and an e-mail address. This would be the office in Medan where the hospital maintains two staff members. In addition, they have two dedicated staff members in the hospital who manage Indonesian patients, one of whom is Indonesian.⁴⁸ According to the CEO of Hospital B, the Indonesians who come to Penang are usually from Sumatra, while those from Java will go to Singapore. Indeed, in Hospital A, where they have been receiving about 4,000 foreign patients a month, 80 per cent of whom are Indonesians, 50 per cent come from Medan, 40 per cent from Aceh, and the rest from Jakarta.⁴⁹

We may tease out a few underlying reasons for the existing patterns of flows. Distance plays a role; but this is layered over with other factors because distance alone cannot account for all the specific flows. In the case of Malaysia and Indonesia, there has long existed a migration system linking the communities in both countries.⁵⁰ The trade and migration links between Sumatra (in particular Medan) and Penang are particularly dense between the ethnic Chinese populations of both places. However, price considerations probably account for the upper middle income groups going to Singapore and the lower middle income groups going to Malaysia.

⁴⁶ Interview by Chee, 10 July 2007.

⁴⁷ Interview by Chee, 10 July 2007.

⁴⁸ Interview with Marketing Manager, Hospital C, 10 July 2007.

⁴⁹ Interview by HL, 7 July 2007.

⁵⁰ Diana Wong, "The recruitment of foreign labour in Malaysia: from migration system to guest worker regime," in *Mobility, labour migration and border controls in Asia*, New York: Palgrave Macmillan, ed. Amarjit Kaur and Ian Metcalfe (New York: Palgrave Macmillan, 2006).

On the other hand, those going to Malaysia from Jakarta would head towards Kuala Lumpur, whilst people from Sumatra tread a familiar path when they travel to Penang.

For traditional flows such as these, global accreditations are not particularly important. For example, the marketing executive in Hospital D said that their Indonesian patients are not bothered so much about JCI accreditation, “the Indonesians don’t ask so much,” and that for them the MSQH certification is sufficient. That it probably is an important consideration for the newer flows of patients, for example from the Middle East, has proved instructive for the Malaysian hospitals.

The intra-regional linkages are however not static and can shift quite quickly. After 9/11, it became more difficult for high income medical travelers from the Middle East to enter the United States for medical care. Medical tourism hospitals in the Asian region competed for these diverted customers. The industry players in Malaysia were initially confident of attracting a flow of co-religionist patients, because it was thought that Muslims from the Middle East would feel more comfortable in another Muslim majority country where it would be easier to obtain halal food for instance. This premise has been proven false, as the majority of Middle Eastern medical travelers diverted to Singapore, or to Bangkok, where Bumrungrad’s Middle Eastern patients now overwhelm the Japanese and the elite Thais. For these newer flows of patients, the factor of “quality” far outweighs the factor of price or religion. In retrospect, this would appear obvious, since this flow has been diverted from the United States, the priority medical destination of the Third World elite. However, the success of Singapore and Thai medical tourist sites in attracting Middle Eastern patients also testifies to the “constructability” of medical tourism. In a leading medical tourist hospital in Bangkok for example, all employees take an orientation course on Islam, and the hospital has a halal kitchen – Thailand’s first – as well as a Muslim prayer room; not to mention a new benchmark in terms of

hospital décor and services that resemble better a five-star hotel.⁵¹

Finally, we should make note of the different layers and streams of people who travel for specific types of medical intervention. For example, Thailand has long been a destination for those who seek out gender reassignment surgery due to a specific historical legacy, as well as cosmetic surgery. South Korea is a destination for high quality cosmetic surgery, particularly for Korean Americans, Japanese, and increasingly the Chinese. These types of medical travel precede the medical tourist industry, contributing to its subsequent development in each of the countries concerned.

“Communication is number one”: role of intermediaries

“Communication is number one,” the marketing executive of Hospital D interviewed by Chee emphasized (11 October 2010). She explained the pivotal role of the liaison team in the marketing department. Foreign patients are handled by the liaison personnel who not only carries out the marketing to foreign patients, but also the communications with them before they actually come. Each foreign patient is taken care of by a member of the liaison team from the point of enquiries, to the follow-ups with the doctors.

The liaison team consists of personnel who speak English, Malay, Indonesian, Mandarin and Japanese. There are also Indonesians in the team. They are selected primarily on their “national” characteristics, to interpret and do translations if necessary, and communicate with the doctors. The doctors will answer emails, but their priority would be to attend to patients who are physically present, rather than the potential patients sending queries by email. In other words, the liaison person is the intermediary between the potential patient and the doctor.

⁵¹ We thank Andrea Whittaker for sharing this information with us.

The liaison personnel form the first line of screening. The marketing executive explained that they have to make certain decisions, "Can we accept this case? ... Do we do these procedures?" The patients have to send their medical reports, X-rays, MRI's, etc., and the doctors will read the patients' profiles through these materials, but they do not communicate directly with the patients. The communication is always through the liaison persons. Sometimes, the doctors may agree to talk to the patients over skype; and this would be considered a "pre-consultation" talk. It would depend on the doctor whether the patient will be charged for this. There is no direct communication with doctors in the sending countries, unless the patient requests specifically for it. The liaison team will also assist in providing information and linking patients up with hotels, transport providers, tour operators, etc., but according to the marketing executive, they seldom have patients who go on tours.

The internet is a central communicating channel, and may even be used for medical consultation. If the patient is unable to make a trip for medical consultation prior to treatment, then the consultation usually takes place through email or skype. To further complicate matters, the marketing executive of Hospital D said that they also have representatives in Indonesia, mostly in Medan, Jakarta, Surabaya; and these "reps" may liaise with the liaison persons on behalf of the patients. In other words, two layers of intermediaries may exist to bridge the gap between the patient and the doctor. In future, they even hope to have a customer service team (in addition to the liaison team) who will handle the patients when they arrive, in her own words, "to handhold the patients at the door".

The use of third party intermediaries may be organised in different ways in different hospitals; and they may function in different roles. For example, a broker affiliated to the Parkway Group oversees 20 agents in Indonesia and three in Malaysia.⁵² Other examples are Sunway Medical Centre, which has an agent in Medan, Indonesia, who conducts talks for the public, meets with local doctors there, and arranges tourism packages that include airport transfers, accommodation for

⁵² Personal communication with broker, February 2008.

accompanying family members, shopping, sightseeing tours, etc.;⁵³ and Mahkota Medical Centre in Melaka, which has a local representative in Indonesia to handle enquiries on a daily basis, while its marketing director and other officials travel fortnightly to Indonesian towns to carry out promotions among the public, the doctors, as well as maintain links with the authorities.⁵⁴ As compared to general advertisements and other marketing strategies, intermediaries are effective precisely because they are rooted in the country, or they have connections there, thus facilitating the point-to-point flows.

Conclusion

Medical care is one of the most sensitive and intimate parts of modern life, and is at the same time one of the most regulated practices by nation-states. The process of how medical care becomes transnationalized, distanced and disembedded from national institutions is bound to be complex. Medical tourism is growing and changing rapidly, and our understanding about it remains very limited. This article suggests that a regional scope and the lens of institutional analysis can be particularly helpful to discern the underlying dynamics at this stage.

By focusing on the Asian region, this article uses two metaphors, global track and national vehicle, to shed light on the intricate relations between universalizing imperatives driven by capital and technology on one hand, and nationally and locally embedded practices on the other. Global tracks without national vehicles are dead, empty space; national vehicles without global tracks can't go far. It is the co-existence of standard tracks and variable vehicles of different types and sizes, moving in different directions, that constitutes the global space. Between global tracks and national vehicles are transnational networks that are historically conditioned, which in turn shape transnational flows at a particular moment. Transnational networks can be seen as specific manifestations of the global space at a

⁵³ *The Star*, "Hospital Holidays – a Growing Business" (August 21, 2004).

⁵⁴ *The Malay Mail*, "Health Tourism Popular," (12 February, 2006).

particular time.

More specifically, this article examines the relations between global tracks and national vehicles in historical evolution and especially the development strategies of medical tourism in Asia. Historically, globalizing forces before 1997 laid the foundation for the development of medical tourism; after the 1997 crisis, governments and the medical sectors in various nations pushed themselves further down the global track in order to address the disruptions brought about by the earlier wave of globalization. The global and the national, the universalistic and the context-specific, become even more deeply intertwined in the actual strategies of developing medical tourism. Governments and the industry actively bring themselves into the established global space through measures of accreditation, packaging and aggressive marketing. But they at the same time tap on and even essentialize their specific national advantages by branding the receiving countries, targeting particular sending countries, and adopting particularistic, face-to-face communications as the main means of marketing. As the supposedly universalistic global standards and norms and nationally variable particularistic practices are so deeply entangled, it is more likely than not that coexistence of global track and national vehicle will continue as a structural feature of globalization in general, and medical tourism in particular, rather than everything becoming “global”.

References

- Carrera, Percival M./John F.P. Bridges 2006: Globalization and Healthcare: Understanding Health and Medical Tourism, in: *Expert Rev. Pharmacoeconomics Outcomes Res.* 6 (4): 447-454.
- Chee Heng Leng 2010: Medical Tourism and the State in Malaysia and Singapore, in: *Global Social Policy* 10 (3): 336–57.
- Connell, John 2006: Medical Tourism: Sea, Sun, Sand and ... Surgery, in: *Tourism Management*, 27 (6): 1093-1100.
- Crang, Philip/Claire Dwyer/Peter Jackson 2003: Transnationalism and the Spaces of Commodity Culture, in: *Progress in Human Geography* 27 (4): 438–56.
- Crooks, Valerie A./Leigh Turner/Jeremy Snyder/Rory Johnston/Paul Kingsbury 2011: Promoting Medical Tourism to India: Messages, Images, and the Marketing of International Patient Travel, *Social Science and Medicine* 72: 726–32.
- Crozier, GKD/Francoise Baylis 2010: The ethical physician encounters international medical travel, in: *Journal of Medical Ethics*, 36: 297-301.
- Deloitte, *Medical Tourism: Consumers in Search of Value* (Washington DC: Deloitte Center for Health Solutions, 2008).
- Diaz, David/Margarita Hurtado 1994: *International trade in health services: Main issues and opportunities for the countries of Latin America and the Caribbean*, Pan American Health Organization, Health Policies Program, Technical Reports Series No. 33, July.
- Ferguson, James 2006: *Global Shadows: Africa in the neoliberal world order*, Durham, NC and London: Duke University Press.
- Goodrich, Jonathan N./Grace E. Goodrich 1987: Health-care Tourism: An Exploratory Study, in: *Tourism Management* (September): 217-222.
- Hazarika, Indrajit 2010: Medical tourism: its potential impact on the health workforce and health systems in India, *Health Policy and Planning*, 25: 248-251.

- Herrick, D.M. 2007: *Medical Tourism: Global Competition in Health Care*, in: *National Centre for Policy Analysis (NCPA) Policy Report No. 304*, November, Dallas, Texas: NCPA.
- Hopkins, Laura/Ronald Labonte/Vivien Runnels/Corinne Packer 2010: Medical tourism today: what is the state of existing knowledge? In: *Journal of Public Health Policy*, 31 (2): 185-198.
- Jackson, Peter/Philip Crang/Claire Dwyer 2004: Introduction: the Spaces of Transnationality, in: Peter Jackson/Philip Crang/Claire Dwyer eds. *Transnational Spaces*, London: Routledge.
- Kangas, Beth 2010: Traveling for Medical Care in a Global World, in: *Medical Anthropology* 29 (4): 344 – 62.
- Khoo, Leslie 2003: *Trends in foreign patient admission in Singapore*, Information Paper 2003/01. Singapore: Ministry of Health.
- Levitt, Peggy/Nina Glick Schiller 2004: Conceptualizing Simultaneity: A Transnational Social Field Perspective on Society, in: *International Migration Review* 38 (3).
- Malaysia Ministry of Health 2003: *Malaysia's Health 2002*. Kuala Lumpur: Malaysia Ministry of Health.
- Nomura Asia Healthcare Research Team 2009: Special Report on Health Care/Asia Pacific, Hongkong: Nomura International, 9 December.
- Pennings, Guido 2007: Ethics without boundaries: Medical tourism, in: Ashcroft, R.E./ A. Dawson/H. Draper/J.R. McMillan (eds), *Principles of Health Care Ethics*, second edition. John Wiley and Sons
- Phua Kai Hong 1991: *Privatization and Restructuring of Health Services in Singapore*, in: Institute of Policy Studies Occasional Paper No. 5, Singapore: Institute of Policy Studies.
- Purcal, John 1989: Some Aspects of the Political Economy of Health and Development in Singapore, in Paul Cohen/John Purcal eds. *The Political Economy of Primary Health Care in Southeast Asia*, Canberra: Australian Development Studies Network, The Australian National University.

- Rabobank International Asia Pacific 1999: *Impact of the Crisis: Immediate and Long-Term Outlook for Asian Health Care Markets*, Singapore: Research Consortium of Rabobank International Asia Pacific, Asia Health Ventures, and The Economist Conferences.
- RNCOS 2007: *Asian Medical Tourism Analysis (2008-2012)*, RNCOS Industry Research Solutions, available at <http://www.rncos.com/Report/IM105.htm> (accessed 25 June 2010)
- Sengupta, Amit 2011: Medical Tourism: Reverse Subsidy for the Elite, in: *SIGNS* 36 (2): 312–19.
- Singapore Medicine 2005: *World-Class Healthcare You Can Trust* (promotion brochure), Singapore: Singapore Tourism Board, HC-043-05-08-01.
- Tourism Authorities of Thailand 2010: *Annual Statistics of Tourism in Thailand 2009*. Bangkok: Tourism Authorities of Thailand.
- Toyota, Mika 2012: Patients on the move: The development of medical tourism in Asian countries, in: Yoshihara, N./A. Takenaka/M. Tsujimoto (eds.) *Global Migration and Ethnic Communities: Studies of Asia and South America*, Balwyn North, Victoria, Australia: Trans Pacific Press, 24-38.
- Turner, Leigh 2007: First World Health Care at Third World Prices: Globalization, Bioethics and Medical Tourism, *BioSocieties* (2): 303-325.
- United Nations Population Fund (UNFPA) in collaboration with The Australian National University (ANU) 1998: *Southeast Asian Populations in Crisis: Challenges to the Implementation of the ICPD Programme of Action*, New York: UNFPA.
- Whittaker, Andrea 2008: Pleasure and Pain: Medical Travel in Asia, in: *Global Public Health*, 3 (3): 271–90.
- Whittaker, Andrea/Amy Speier 2010: Cycling Overseas: Care, Commodification, and Stratification in Cross-Border Reproductive Travel, *Medical Anthropology* 29 (4): 363–383.
- Wilson, Ara 2011: Foreign Bodies and National Scales: Medical Tourism in Thailand, in: *Body and Society* 17 (2&3): 121–137.

- Woodman, Josef 2008: *Patients Beyond Borders: Everybody's Guide to Affordable World-Class Medical Tourism*, Chapel Hill, North Carolina, USA: Healthy Travel Media, 2nd edition.
- Xiang Biao 2012: Labor transplant: "Point-to-Point" Transnational Labor Migration in East Asia, in: *The South Atlantic Quarterly* 111 (4): 721-739.
- Yeates, Nicola 2011, Going Global: The Transnationalization of Care, in: *Development and Change* 42 (4): 1109-30.
- Youngman, Ian 2008: Medical Tourism 2008 - The Worldwide Business Guide, *Research and Markets 2007*, available at <http://www.researchandmarkets.com/reports/569409> (accessed 26 June).
- Zarrilli, Simonetta/Colette Kinnon, eds. 1998: *International Trade in Health Services: A Development Perspective*, Geneva: United Nations Conference on Trade and Development.

The rise of a transnational healthcare paradigm.
Thai hospitals at the crossroad of new patient flows

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In today's world, people move more, move further, and move for increasingly varied reasons such as work, studies or leisure. Seeking health care away from one's home is a part of this trend and many patients do not hesitate to cross national borders to consult a physician or get a surgical intervention. This article examines this form of mobility towards Thailand from both global and regional perspectives. This situation involves long-distance patients travelling from highly industrialized countries and closeby neighbors, such as Laotians, who may just cross the border to get treated a few kilometers away from home. Constrasting these senarios complicates the findings by studies on "medical travel" as it brings in heterogeneity and variability. There are significant differences in patients' motives, in the social implications of their cross-border health-seeking behaviours, and in the responses by health infrastructures and authorities in both the host country (marketing, regulation or even quality of care) and the patients' lands of origin (policies, intermediaries, and emerging

⁵⁵ I would like to thank Joseph Foy, Bertrand Lefebvre and Laurent Pordié for their inputs and reviews.

specialized agencies). This paper takes this situation as a case study to describe and explain the rise of a new transnational healthcare paradigm.

The opening of borders, faster information flows and increased mobility have a significant impact on health recourse and medical practices. Besides the rapid spread of diseases across national borders, transnational health also affects healthcare patterns and leads to mixed outcomes. Although there is a worldwide standardization of certain medical practices and the use of medication, disparities in health persist or even increase between economically advanced and emerging countries and the poorer nations. High-quality health care services are not available in all countries. From these disparities arise trends driven both by practitioners and by patients from around the world. Medical practitioners cross borders searching for facilities where they can practice their skills and earn a livable wage (Vaillant 2008). Patients seek hospitals outside of their own country, searching for adequate and preferable treatment. This article deals with cross-border patient mobility at short and long distance, from regional to global scale. Particular focus is given to the example of Thai hospitals located at the crossroads of new types of medical travels.

The mobility of patients on a transnational scale, described as "medical tourism", best illustrates the globalization of healthcare. The phenomenon has indeed spread worldwide and generally, but not only, involves patients originating from economically advanced countries and hospital facilities located elsewhere (Glinos *et al.* 2010). Many patients do not hesitate to cross national borders and sometimes travel thousands of kilometers in order to consult a well-known doctor or to benefit from fast, high-quality and relatively cheap healthcare services. Thailand, located in the center of Southeast Asia, has played a leading role in the emergence of this new kind of health recourse since the late 1990s. Along with India, this country receives in Asia the majority of foreign patients traveling for healthcare worldwide (Connell 2006; Bochaton/Lefebvre 2008).

In addition to the global attraction of the Thai health infrastructure, it is interesting to examine cross-border patient mobility at the regional level. In the Lao-Thai border

area, new behaviors appear related to these forms of therapeutic mobilities. A significant portion of the Laotian population is involved in this practice, which is directly connected to the recent political and economic opening of Lao People's Democratic Republic (Lao PDR). This phenomenon highlights the development gap between Laos and Thailand, and specifically the healthcare disparities between the two countries. These movements are also facilitated by the proximity and historical links between the populations living along the Mekong.

Through the study of cross-border patient mobility at regional and global scale, this article shows how transnationalism contributes to the modification of Thai hospitals' activities, and more generally to the building of a cross-border healthcare paradigm.⁵⁶ It is divided into three parts. The health and economic contexts, both regional and global, will be first presented to understand the factors leading to health mobility. I will then study the ways patients learn about health facilities in Thailand and how their decision is eventually acted upon. This involves the access to information and how Thai hospitals skillfully aim their communication strategies at these new foreign patients. Finally I will discuss the role this new patients' flow in shaping healthcare, and specifically the kind of change that occur in both the receiving country (Thailand in our case) and in the patients' countries of origin.

An effective Thai healthcare system attracting foreign patients: historical development and recent trends

Before describing health mobility, it is expedient to present the context in which it takes place. What are the push and pull factors which attract Laotian and other international patients to Thai healthcare facilities? After introducing the attractive potential of provision of care in Thailand, I will then consider the transnational

⁵⁶ The findings presented in this paper result from a doctoral project carried from 2004 to 2009 (University of Paris Ouest Nanterre la Défense and Institute of Research for Development). Household surveys were conducted in Lao PDR (2006-2007) along the border with Thailand regarding the issue of cross-border healthcare seeking behavior. Concerning the research on medical tourism, many interviews were conducted with medical professionals, marketing and operation managers of corporate hospitals, and key members of different ministers or professional organisations in Thailand (Bangkok) and India (Delhi) (Bochaton/Lefebvre 2010).

contexts between neighboring countries and globally, as well as the motives of their respective citizens-turned-patients, in order to understand the origins of these movements and identify commonalities and peculiarities in these two cases of cross-border healthcare.

The Thai healthcare system

Thai public hospitals are currently facing difficulties with funding. Although their budgets are unbalanced, the healthcare system of the country can still be described as successful. Initially introduced in the late nineteenth century by the royal family, the health environment has taken full advantage of the country's economic growth to develop, modernize and extend to the entire population.

In 1888, King Chulalongkorn, the great modernizer of the Kingdom of Siam, built the first modern hospital, namely Siriraj Hospital in Bangkok. The foundations of the current healthcare system were then laid by Prince Mahidol (1892-1929) commonly called "Father of modern medicine and public health in Thailand" (Ellis 1936). Prince Mahidol is still widely associated with the advancements of medicine, which is a source of pride for many Thais. The national press regularly publishes special reports in memory of the Prince, describing the many medical advances made possible by him (Prince Mahidol Award Foundation 2002 and 2007). Certain private hospitals in Bangkok also use the image of the former prince as part of their marketing campaign to relate their work to the royal family: "In memory of our beloved Prince Mahidol... May the medical field continue in his footsteps" is the title of a Bangkok Hospital advertisement. Today, the royal family led by King Bhumibol Adulyadej, is still actively involved in public health projects (Chamnan 1991). The king launched mobile medical units (also called the Royal Medical Units) in 1967 to travel with him and provide treatment during official visits to remote rural areas. Modern medicine and Thai monarchy thus have strong links which provide mutual legitimacy.

In addition to the important role of the royal family in health affairs, the economic growth and the relative political stability have contributed to the expansion of

biomedicine throughout the country and to the development of healthcare provision during the twentieth century. In a similar vein as the general development of the country, the healthcare developments since 1961 have followed five-year planning cycles. The objective of the first few plans was the expansion of health coverage throughout Thailand with the construction of clinics, district and provincial hospitals. The later plans focused their attention on the installation of medical equipment in these health facilities. Finally, the last major project of the Ministry of Health was the establishment of universal health coverage in 2001. The stated goal, written in the constitution is that “all Thai people have an equal right to access the quality health services”. The national health expenditures have thus followed economic trends and have increased from 2.7% of the national budget in 1969 to 8.3% in 2007 (approximately 0.4 to 1.4% of GDP) (Ministry of Public Health, Thailand 2008). Additionally, with the rapid economic growth experienced since the early 1970s, the private sector has developed significantly, initially in Bangkok and spreading later to other provinces during the 1990s. Between 1970 and 2006, the number of private hospitals increased from 23 to 344, of which 70% are located outside of Bangkok. During this entire period, Thai biomedical training enjoyed proactive government policies under the auspices of the royal family. The technical level of physicians is thus relatively high, as a significant number do part of their training abroad, primarily in the United States or Australia. Finally, even if the Thai healthcare system is good, how can the ability of Thai hospitals to attract large numbers of foreign patients be explained? Indeed, many other countries have reliable hospitals, but few have an attractive power outside their national borders. What are the local characteristics and the specific contexts which led to this situation?

The Asian economic crisis and the medical travel industry

The link between the Asian financial crisis and the rise of medical travels may not be obvious at first, yet it is clear. During the 1990s, while the private health facilities proliferated in line with the strong economic growth, upper class Thais gradually turned away from public facilities, preferring private clinics and hospitals. However,

following the 1997 crisis, the majority of these wealthy patients deserted private consultations and returned to state hospitals. Many hospitals in Bangkok collapsed with the crisis, others kept their business by developing new strategies. The managers of some facilities searched for new types of patients, mainly from abroad, to fill the void. Several hospitals in Bangkok launched marketing campaigns targeting wealthy classes and expatriates living in neighboring countries. Once these regional targets were reached, the leaders of some of the largest hospitals in Bangkok pursued their plan on a global scale, giving rise to the phenomenon of international health mobility, described by them as “medical tourism”. As mentioned by Ara Wilson (2011: 134), “the internationalization of medicine in Thailand has been produced as an explicitly national project. Indeed, Thailand’s medical tourism presents a case where the nation-state has been strengthened rather than weakened through economic globalization” (Wilson 2011).

The majority of foreign patients come from economically advanced countries (Japan, the Middle-East, US, Canada, Europe). They choose to seek treatment abroad because of financial reasons, waiting periods, for comfort, or again lack of biomedical technologies in some cases. In 2004 for example, an open heart surgery costing 30,000 USD in the United States cost 14,250 USD in Thailand. Long waiting periods of several weeks or months are a significant reason for patients to seek care abroad, especially those from Canada and Britain. Finally, with the relatively recent construction and the abundance of healthcare staff (due to low pay), private Thai hospitals offer a level of comfort and quality of care hard to match elsewhere. For all of these reasons, Thailand receives the largest number of international patients, followed by India. In 2005, private hospitals in Thailand received more than 1.5 million foreign patients.

Development gap, geo-cultural proximity and cross-border healthcare

The Thai-Lao border, marked by the Mekong River along most of its 1,754 km length, is characterized by major political differences as well as significant economic and health disparities. In 2006, life expectancy at birth was estimated at 72 years in

Thailand and only 61 years in Lao PDR (WHO 2008). Besides the discrepancy between health and social indicators, the two countries also differ in the type of care available on both sides of the border. While health facilities on the Thai side are attractive, Lao PDR has difficulty developing a high-quality and equally distributed primary healthcare network throughout the country. The problems and failures of the healthcare system in this country therefore push Laotian patients to seek health care abroad.

The founding of the Lao People's Democratic Republic in 1975 marked the real beginning of public health in the country. Before this, no modern and organized healthcare system existed in the country. Traditional medicine, consisting of rituals and medicinal plant- and animal part-based remedies represented the most important form of medical knowledge and therapeutic recourse. Since 1976, the number of public facilities at the central, provincial and district level has grown rapidly. However, in some areas, access to care continues to be limited due to geographical features. Despite the strengthening of the healthcare system in Laos, a number of problems persists. The doctors' relatively low level of training leads to often imperfect diagnoses (Mobillion 2010; Striegler 2005). Additionally, the extremely low salaries of doctors (between 30 and 50 USD per month) and other health workers force the majority of them to do additional work outside of the hospital, reducing their time spent in public facilities. This situation also encourages the risk of corruption within the healthcare system by encouraging hidden payments from patients to hospital staff: "Health workers charge for 'free' medicines" (Stuart-Fox 2006) is one aspect of these informal exchanges. All these elements have led to a crisis of confidence among Laotians regarding their public health system, as was observed by several authors (Hours/Selim 1997; Pottier 2004; Mobillion 2010). The combination of disappointing elements on one side and attractive elements on the other provides the context for cross-border healthcare seeking behavior, a phenomenon seen all along the Lao-Thai border. Household surveys I conducted in 2006 in several border towns⁵⁷ and villages showed that between 7 and 25% of

⁵⁷ Several study areas were selected: in the capital Vientiane and the provinces of Bokéo, Bolikhmasai,

Laotians living in these areas have been cared for in Thai hospitals (Bochaton 2009). Whether for the treatment of road accidents, hypertension during childbirth, infectious diseases, and other problems with multiple complications, reasons for using the Thai services are multiple and expose the clear difficulties of Laotian facilities to respond to the needs of the population. This type of border crossing is more motivated by the search for quality care, rather than the possibility of financial savings as the price of care is higher in Thailand than in Laos⁵⁸.

If the factors and motives differ between Laotian and international patients, there is nevertheless a similar attraction to Thai hospitals across country borders. From luxury hospitals in Bangkok to smaller facilities located near Thai borders, the healthcare system in Thailand is now at the crossroads of new patient flows.

Inducing border crossing by revisiting medical communication

Compared to the use of care facilities within national borders, which follows well established treatment norms known and shared among the citizens, how do mobile patients come to choose a healthcare facility abroad? In addition to the medical reasons and/or financial motives discussed above, how do foreign patients acquire knowledge of Thai facilities and complete their journeys? How do Thai health facilities manage to be attractive and to establish their image abroad, from neighboring countries to more remote regions? By using new communication technologies and through the manipulation of physical social networks⁵⁹, the Thai private medical sector develops a communication strategy turned exclusively towards foreign patients.

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⁵⁸ While a consultation is free in a public Laotian hospital, it costs between 200 and 600 bahts (7 to 20 US\$) depending on the type of facility chosen in Thailand. Additionally, if one night spent in Mahosot Hospital in central Vientiane costs between 20,000 and 135,000 kips (2,5 to 17 US\$), the cost could surpass 10,000 Bahts (approximately 333 US\$) in certain private Thai hospitals.

⁵⁹ I use the term physical to distinguish these networks from the virtual, internet-based social networks.

“Medical tourism”: a redefinition of the therapeutic experience

Cross-border patient mobility depends on successfully informing potential patients and the promotion of the destinations includes a wide range of marketing materials such as flyers, booklets, and websites (Crooks *et al.* 2011). In Thailand, the communication developed by private hospitals reveals a constant mix between medical and recreational areas. This contributes to deeply link medical and travel experience in the users' imaginary. Consequently, if we have so far preferred the term “cross-border patient mobility” to “medical tourism”, the latter may be justified under the following development.

A virtual tour of of the largest private hospitals websites in Bangkok helps to grasp the importance of this digital platform. Each website competes esthetically in terms of access to information, illustrations and multiple choices of languages. The strong competition among the hospitals in Bangkok in order to attract more and more foreign patients is also visible on these sites. The website represents the only interface between the healthcare facility and the patient, when the patient is still at home trying to decide which hospital to use. This important step in the decision-making process comes at a time when thousands of kilometers separate the patient and the doctor, the two principal actors in this relationship. The internet site seems to enable a real communication which would otherwise be impossible due to connection time and geographic distance. It thus creates closeness between actors, despite the physical distance. The carefully designed structure of these websites shows the desire to embody an idea of closeness – continuity in the cyber world. The welcome page of the Bumrungrad International Hospital website shows the wide variety of available information and the extent of possibilities for visitors seeking care. The potential patient can exchange messages with various specialists to find one capable of treating him/her. If the terms and conditions of care are agreed upon by the physician, the visit can be organized by making an appointment. An online software provided on the hospital website gives the opportunity for the patient to

calculate in advance the cost of visit and/or surgery according to the needs. All these functions facilitate the organization of the patient visit to the medical facility and gradually transform the medical experience.

Aside from the logistical support, the website also brings the visitor into the virtual world of the hospital: it stimulates the imagination and creates high expectations. Indeed, the photographs of buildings and interior furnishings seen on the hospital sites more closely resemble a hotel than a healthcare facility and echo the expression “five-star hospital” used regularly in the press and by hospitals managers. Traditional hospital architecture, with a purely practical emphasis, is being abandoned in favor of new esthetic architectural designs, justified by their impact on the healing process⁶⁰. This transformation is well underway in the Thai capital. So much so that it is sometimes confusing to western visitors unaccustomed to such a mix of styles, including the ostentatious display of modernity and design in a healthcare facility. Even the vocabulary used to describe the different areas within the facility (Lounge, Single Deluxe, Premium Atrium Suite, Sky Lobby Atrium, etc.) seems to blur the medical function of the building with the functions of relaxation, comfort and luxury instead. Philippe Bachimon (2001) writes about the “creation of desire for locations or the renewal of locations through tourism” to describe the impact of leisure activities on the sites visited. This assertion seems quite transferable to our case study. The hospital, as a spatial entity, is indeed re-created through medical tourism, with its new norms and expectations.

In addition to the Internet, which makes distance irrelevant and features hospitals in a new way, the international press has also played an important role in promoting private hospitals in Bangkok to potential foreign patients: “Sea, sun, sand and surgery” (Moorhead 2004 in *The Guardian*) or “A little sightseeing, a little face-lift” (Donehy 2006 in *Los Angeles Times*) are some of the sensational titles used by journalists to describe the phenomenon of medical tourism. This development strongly emphasizes changes in the field of health and its marketing.

⁶⁰ See studies on “therapeutic landscape” (Gesler 2005) or “therapy by design” (Gesler *et al.* 2004).

Moreover, with the expansion of the medical tourism industry, a growing number of agencies, sometimes exclusively specialized in this field, have emerged to inform about tourism opportunities, treatment options, and to assist interested patients with selecting hospitals abroad, visa applications and other paperwork. These companies often take part to trade shows and other promotional events designed to attract potential patients (Crooks *et al.* 2011). The Thai government takes an active role in promoting medical tourism including the sponsorship of these events: for example, the Tourism Authority of Thailand (TAT) supports for the first medical and wellness trade fair in Thailand (September 11 to 14, 2012), with over 100 companies from more than 20 countries in Bangkok.

The role of social networks and their manipulation

Apart from international mobility, what other communication strategies are used by Thai hospitals towards potential patients in the Lao PDR? Advertisements in Laotian newspapers or on billboards in Vientiane show an obvious presence of Thai hospitals in Lao PDR. However, according to the surveys I conducted, advertising has little impact on the decision to be treated across Mekong River or on the choice of which healthcare facility to visit. Out of 55 respondents, only 2 mentioned the possibility of having been indirectly influenced by advertising. In reality, strategies of cross-border patients are mainly guided by word of mouth between family members, neighbors and other acquaintances. Throughout the decision-making process including logistical and financial considerations, the patient's social network significantly influences the treatment itinerary. Physical social networks are therefore a powerful analytical tool for understanding the production of cross-border movements (Bochaton 2009).

Being aware of how information is spread through intermediaries, actors from private Thai hospitals or insurance groups develop strategies to infiltrate the Laotian community in order to occupy a more prominent role in social relations which would

accompany their visual presence. Between medical pretext and disguised door-to-door selling, certain cross-border patients (especially those living in the border towns and even more so in Vientiane) receive home visits from doctors and administrators from some private Thai hospitals near the border. These visits serve two purposes. First, they allow the doctors to monitor patients with chronic diseases or those recovering from operations. Second, they allow the doctors to maintain contact with the most regular Laotian patients. Some are even met with an elaborate bouquet of flowers or with small gifts bearing the hospital logo. The most loyal patients are occasionally invited in small groups to a restaurant. In this way, the groups of private hospitals intend to extend the relationship with their patients outside a purely medical context, and thus create a climate of confidence. By reversing the itinerary – the hospital *comes* to the patient, rather than patients going to the hospital – the hospital administration establishes a new form of relationship between patient and care-giver. The impact of these meetings, albeit not widely in used yet, is as real for the patients visited as for their family and friends, who will surely hear about the event later. The visit will not go unnoticed by neighbors, who may discuss it between themselves.

I also observed that the Laotian shopkeepers, who represent a solid patient base of the Thai border hospitals, were a targeted group of these visits. These individuals possess a growing economic power which allows them to be treated regularly in Thailand. They also benefit from their strong personal connections, gained through their positions, which have great influence in the shaping of social networks. By visiting the shopkeepers, the private hospital managers are well aware of their ability to reach a larger portion of Laotian society: shopkeepers have numerous interactions with the population, and therefore possess an extended social network. Even more so than shopkeepers, Laotian doctors and pharmacists are in the best position to advise their patients to seek treatment in Thailand. Several factors, observed and learned through interviews, allow me to believe that certain agreements exist between Laotian medical personnel and private Thai actors. For example, some border hospitals seek to build relationships with doctors in Vientiane by offering visits to their facilities. These visits allow the doctors to become aware of the different

services and equipment available in these hospitals. These trips are not organized with the intention of training the healthcare staff. Instead, they take advantage of the healthcare disparities on each side of the border and try to encourage Laotian doctors to send their patients to Thailand for medical tests which aren't available in Laos. As there is no formal policy between the two countries regarding this issue, the agreements between Thai hospitals and certain Laotian doctors are hidden. According to one doctor from Mahosot Hospital in Vientiane, "we suspect that there are corrupt doctors". Similarly, a Thai insurance company (Ayudhya) whose office is located discreetly in the outskirts of Vientiane includes Laotian medical staff in its team. The right hand of the Thai representative of this company is indeed a pharmacist and owner of a large pharmacy opposite the Mother and Child Hospital in the centre of the capital. Her husband is a physician responsible for performing health reviews of future subscribers. Even if the insurance company is not obviously visible within Vientiane, it is supported by a network of Laotian healthcare professionals. This network represents the most effective and credible method of distributing information among Laotian patients.

The building of good relations between Thai hospitals and Laotian doctors and the contribution of Laotian healthcare professionals who represent a health insurance company in Vientiane are examples of the power of private Thai organizations. These examples illustrate well the ways in which these groups adapt their methods of communication with potential patients in a foreign country. Private hospitals in Thailand therefore target social networks to expand their influence in Lao PDR. Their strategy consists of having their name marketed by the Laotians themselves and not only through booklets or other advertising media. The force of social networks is shown in the emergence and self-organization of cross-border care (Bochaton 2009). The skill of the private hospitals consists of taking advantage of these networks.

To reinforce and increase patients' flows from the Lao PDR and around the world, private Thai hospitals located either in Bangkok or near national borders develop

specific, although different in form, communication strategies which gradually transform the function of the hospital in Thailand and strengthen its commercial potential. As we will see now, the various forms of cross-border healthcare presented in this article transform not only Thai hospitals but also health systems in the patients' countries of origin.

From the country of origin to the host country: an ambivalent impact

On money and brain-drain in Thailand

The effects of cross-border patient mobility on the Thai health system are far from uniform. Other than the financial impact, the management of foreign patients also drives large restructuring which can, among other things, influence the professional choices of medical staff and the care of local people. From a financial point of view, transnational health-seeking practices allowed a certain number of private hospitals in Bangkok to recover from the Asian financial crisis of the late 90s. This industry niche now represents a major earner of foreign currency. In a similar manner, the fact that Laotians began using trans-border care contributes to the dynamism of the private Thai hospitals located near the border. Indeed, the prices for foreign patients are 10% higher in these facilities. The example of a private hospital I have studied and which was located just across the Mekong from Vientiane confirms this situation: 50% of the patient base is coming from Laos, making this hospital significantly dependent on its neighbor. Generally, private Thai facilities greatly benefit from admitting patients from just across the border, as well as very far away. However, large numbers of Laotians also seek health care in public hospitals. For these facilities, the cross-border circulations can sometimes represent financial burden contrary to the incomes made by private facilities.

Regardless of this cross-border phenomenon, the public healthcare sector in Thailand is going through significant internal structural problems, including maintaining a balanced budget. Universal coverage, established in 2001, has proved

to be incredibly costly⁶¹. In 2004, the debts incurred by district hospitals surpassed one billion Bahts⁶² and those from provincial hospitals were almost 300 million Bahts. From a regional perspective, the North and Northeast of Thailand, both zones bordering Laos, face the worst budget problems. 40% of public hospitals in the North and 45% in the Northeast of the country ran a negative balance sheet that year (Ministry of Public Health 2008). In this context of diminishing resources, the cross-border health-seeking behavior of Laotians becomes a touchy subject, especially when these patients cannot afford the costs and thus benefit from free treatment by the hospital. While this situation is not very common, the cross-border health-seeking is misperceived as a fiscal burden on public hospitals in Thailand. This misperception is even stated by the national media: “Non-Thais prove burden to border medical services” (*The Nation* 1996). The effects of cross-border healthcare on Thai facilities are differentiated and produce mixed reactions according to the parties concerned. Discreet control measures and restrictions in the public sector compete against the strengthened influence of private hospital groups across the Mekong. These actions have opposite effects, between an increased separation and a progressive blurring of the border.

Transnational health-seeking trajectories, especially of the international type, also indirectly affect the structure and organization of the Thai healthcare system. The phenomenon of Thai doctors leaving the public sector for jobs in private hospitals began in the 90s with the growth of the private sector. This trend could very well increase with the success of “medical tourism” and the promise of high salaries. Also, the return of economic growth and to some extent the influence of medical tourism on local practices has changed the behavior of the Thai upper class, which after progressively abandoning private consultations after the crisis is now using them again. Data from the Thai Ministry of Health show that the public healthcare system was strengthened by 1,188 new medical graduates in 2006. However, 777 public

⁶¹ The reason for this problem lies in the inadequate per patient payments given to hospitals and the financial burden of this measure. Indeed, fees paid by patients qualifying for special assistance (low income people, student, war veterans) amount to 30 Bahts regardless of the medical procedure done.

⁶² 1 US\$ = 29,8 Bahts (October 2010)

medical doctors also resigned that year (Ministry of Public Health, Thailand 2008) which explains why certain small health facilities including health centers have been abandoned by physicians. To avoid too large of a misappropriation of medical personnel to the private sector, the Thai ministry allows public sector doctors to work part-time in private hospitals or private clinics. In 2003, a survey revealed that two-third of public-sector doctors have secondary employment in a private facility, allowing them to increase their income by more than 100%, but at the expense of quality service in the public sector (Herbreteau 2007). Although this is not the only factor, therapeutic travel increases the demand for qualified healthcare professionals in the private sector, which accelerate the flight of doctors towards this sector. A real competition is occurring in Thailand, regarding the redistribution of medical human resources with the private healthcare sector being reserved for foreign patients and the public sector for Thai patients (Pachanee 2006). Similarly, we can now fear a new form of segregation within healthcare facilities. Bangkok Hospital, a large private hospital is a good example of this with its two recently built buildings, one serving only international patients, the other serving only domestic.

Some effects in the patients' countries of origin

The patients' countries of origin are also impacted by the departure of some of their nationals. The implications differ between each country and require specific discussions according to the countries involved, their geocultural proximity with Thailand and patients' motives.

The sustained increase of patients' mobility in recent years is beginning to cause concern to doctors and dentists in some highly industrialized countries. They fear a huge diversion of patients from the national health structures and therefore adverse financial consequences on the current system. In addition to structural effects, the phenomenon raises concern of the quality of care for the patients as well as the medical consequences which could result from surgical procedures (Turner 2012). Some articles available in the press highlight the dangers of medical tourism, sometimes excessively. For example, the paper titled "Les horreurs du tourisme

médical” (“The horrors of medical tourism”) published in a French weekly magazine called *Marianne* (Saporta 2006) solely underscores the potential negative effects, using shortcuts, identifying medical tourism with organ trafficking and its rapid international spread. However, the transnational practice of patients also represents an advantage for private insurance companies. With rising costs, busy healthcare systems and an aging population, it becomes increasingly attractive for some companies to cover the travel and medical expenses of their clients to be treated in Thailand, instead of in Europe or the United States. More and more American insurance companies include coverage of medical procedures performed abroad in their contracts. Some even have direct agreements with hospitals in Thailand or elsewhere. Finally, in addition to the actual effects of medical tourism in the countries of origin of the patients, the phenomenon opens the door to similar trends in other forms of personal services. How far is the transfer of skills in healthcare possible? In a similar manner, retirement houses have been built in Thailand to accommodate Japanese retirees as well as wheelchair accessible welcome centers designed to greet people coming from some Scandinavian countries. It is not known how each other’s interests will be reconciled in the near future and which unique organizations will be made from the use of this healthcare disparity.

Lao PDR shows a very different profile, due to the geo-cultural proximity and the development gap between the two countries. I will focus on this country for the remaining of this section as this kind of situation is largely overlooked in transnational studies and in the literature on cross-border healthcare specifically, and therefore requires more scrutiny. As described above, the search for quality medical care is the main motive of Laotian patients who cross the border to receive treatment in Thailand. These movements reveal the political failure of the Laotian government to provide high quality infrastructure to the entire population throughout the country. Moreover, these forms of health mobility arise within a complex historical framework and in a context where Thailand largely dominates the economic and cultural exchanges. Beyond the medical issue, healthcare seeking behaviors thus cover a political dimension that leads health officials and the public sphere of the Lao

PDR to use specific actions to try to slow the flight of the patients (ironically, many of the high-ranking officials go to Thailand for treatment), showing the growing influence of Thailand in Laotian society. One aspect of the Laotian reaction is to criticize the border-crossing practice through a variety of channels. Whether in the discourse of the members of the Ministry of Health or in newspaper articles, movements towards Thailand are often portrayed as a fad: "Doctors at Mahosot Hospital are concerned that patients who choose to go for treatment in Thailand are merely following fashion instead of good medical advice" (Xayxana 2005). Here, the patient is not seen as searching for quality care, but rather portrayed as a casual consumer. This portrayal aims to discredit the patients who cross the border to Thailand, and thus alleviates the political obligations of the Laotian government by not meeting the needs of these individuals. Moreover, the fact that cross-border health-seeking behavior removes, in a way, patients from the Laotian national health system is seen as an unpatriotic in the eyes of the party: "Lao people should help the Lao economy by using the local medical services (...). Economic development in Laos is still the duty of Lao people" (*Ibid.*). The loss of accountability of political bodies in Lao PDR continues and individuals seeking care pass from the status of "consumers" to that of "culprit". The financial argument regarding the transfer of money to Thailand and the supposed loss to the Laotian economy is at the heart of the criticism.

Despite these perceptions and these discourses, the departure of many Laotians to Thai hospitals stimulates awareness regarding the need for progress and drives the actions of some Laotian healthcare actors. Healthcare facilities in Laos appear to imitate the functioning of their neighbor's establishments through the purchase of new equipments and the construction and the rehabilitation of infrastructures. The underlying idea is that if the Laotian hospitals can look like Thai hospitals, more Laotian patients who might otherwise have sought treatment in Thailand might stay in their country for treatment. New medical facilities and equipment illustrate the will of the Laotian government to compete with Thailand in order to escape today's unequal relationship. However, the desire to acquire medical equipment sometimes leads to absurd situations, which are also maintained by international agencies. In a

hospital in Vientiane, a CT Scan was only used by two patients per day. Does this situation really justify the acquisition and installation of this machine, which is also available elsewhere in Vientiane? The question of repayment is not an issue here as this was a donation from the Japanese International Cooperation Agency. The acquisition of medical products in Laos follows neither a medical nor an economic logic. When we know that hospitals in Laos have trouble obtaining new medications and maintaining stable supplies, the pertinence of the decisions and the agreements reached between Laotian authorities and international funders appears questionable.

In addition to the transformation inside the Laotian hospitals, there is also momentum towards healthcare privatization⁶³, justified to counter Thai influence and to “improve health care in Laos and reduce the number of people crossing the border to Thailand for treatment” (Somsack 2007). When I asked a senior party official during an informal meeting in Paris what were the strategies proposed by the government to improve the healthcare systems in Laos, he answered that “the government [had] the desire to allow room for the private sector so that the population does not leave for Thailand.” Cross-border healthcare mobility is at the center of government thinking; it creates a political environment conducive to the development of a private healthcare sector. The current healthcare project only seems to consider the wealthy class of Laos who seek private medical care, at the expense of the great majority of the Laotian population who cannot afford any option other than public services. These developments may very well exacerbate unequal access to care.

The transnational flows have varying impacts according to the patients’ country of origin. This heterogeneity is important to stress once again. The reception of international patients in Thai facilities is largely based on economic factors and is seen as either a financial gain or burden to Thai hospitals. Conversely, these movements are perceived in the countries of origin as a political or social issue. The

⁶³ The Ministry of Health in Vientiane wrote a decree in 1998 to allow foreign investors to build private hospitals. This text, initially valid only in Vientiane, will involve all major Laotian cities in the near future.

proximity and complexity of relations between Laos and Thailand make this cross-border mobility a political issue, the consequences of which can be observed in the political realm, as well as healthcare facilities. Alternatively and while they certainly pay attention to medical tourism, geographical distance and lack of close relationships between distant countries and Thailand do not lead authorities to rethink their health system. Although it is often presented in the news, there is still a long way before the medical tourism industry really challenges health policies in regions like Far-Eastern Asia, the Middle East, Europe or the US. This being said, some actors in the health sector in these locations, such as insurance companies, are beginning to take advantage of the situation, especially given the difference in costs. Ultimately, cross-border patient mobility has not yet led to a concerted international agreement between the various actors. What has occurred instead, has involved minor adjustments according to the logic of each group involved.

How, then, should we understand transnational healthcare? Is there a new paradigm at play? This could be the next challenge for the states, which will have to find a new frame matching patients' flows and the organization of national health systems.

Conclusion

Today's transnational flows of patients illustrate an increasing world-wide interconnection in a field, that of healthcare, which was until then largely confined to national borders. "Healthcare consumers everywhere are becoming more individually responsible for their own health behaviours and treatment decisions" (Kearns / Barnett, 1997). Among these treatment decisions, some may include a hospital located thousands kilometers from home. Taking Thailand as a case study (perhaps also transferable to other contexts), this paper has shown that hospitals are now at the crossroads of new types of patients flows and see their functions redefined. The hospital environment, its interior design and communication strategies are thus gradually transformed. All this contributes to transforming the perception of hospitals in the patients' imaginaries.

The emergence of new forms of “healthcare territoriality” that allow therapeutic recourse to take place outside the territory of origin transforms international legal, political, economic and medical environments. More than interconnection, we should indeed speak of interdependence between countries. From the finding of a dependant relationship of Lao PDR towards Thailand in terms of supply and quality of care, this article has also shown that dependency can also exist in the opposite direction: Thai private hospitals located near the border receive large payments from Laotian customers, which explains the invasive strategies developed in Laos to attract more and more of these patients. This is also true at a global scale: patients living afar save time and money by coming to hospitals in economically emerging or developing countries. These facilities, and by extension the host country, are very keen to receive foreign patients, and consider this new health niche with the utmost importance. The question to ask, therefore, is: how long will it take for international rules to be drafted and implemented to address this situation?

This study of cross-border patient mobility at the regional and global levels is an invitation for health geography to shift its focus from the nation-state as the conventional unit of analysis in order to be able to tackle the complex issues brought about by globalization processes. By going beyond the nation-state, it is then possible “to explore the complex scenarios that emerge from the dialectic interaction of descendant nation-state and ascendant transnational spaces” (Robinson 1998). This would help to frame what I call a new transnational healthcare paradigm – in which the role of national boundaries and policies on therapeutic recourse is dramatically diminishing – and its consequences on the territorial dimensions of health care. This rising paradigm does not discard the role of the nation-state in health affairs. It should instead allow for a consideration of health issues at the crossroads of new territorial assemblages. From a political perspective, these new territorial assemblages are thus based on a combination of decision-making capacity shared among public and private stakeholders, nationals and foreigners, formal or informal players, each with their own logic and their own territorial base. The national level is

overwhelmed, and global forces generated by globalization give rise to process of interaction between various institutions and bodies. In the context of globalization, a transnational healthcare paradigm is then necessary to catch the complex imbrications between the different actors playing on health issues at various territorial levels.

References

- Bachimon, Philippe 2001: La mise en désir des lieux ou la réinvention des lieux par le tourisme, in: *Café Géo*, <http://www.cafe-geo.net>, n°249.
- Bochaton, Audrey 2009: « Paï Thaiï, Paï fang nan, « aller en Thaïlande, aller de l'autre côté ». Construction d'un espace sanitaire transfrontalier : le recours aux soins des Laotiens en Thaïlande », PhD Thesis in Geography, Paris Ouest Nanterre la Défense University, 451.
- Bochaton, Audrey/Bertrand Lefebvre 2010: Interviewing elites. Perspectives from medical tourism sector in India and Thailand, in Michael Hall (eds.): *Fieldwork in Tourism: Methods, Issues and Reflections*, London: Routledge, 85-95.
- Bochaton, Audrey/Bertrand Lefebvre 2008: The rebirth of the hospital: heterotopia and medical tourism in Asia, in Winter, Tim/Peggy Teo and T.C. Chang (eds.): *Asia on Tour: Exploring the rise of Asian tourism*, London: Routledge, 97-108.
- Chamnan, Rodhetbhai 1991: Role of monarchy in Thai political and social development with special reference to King Bhumibol Adulyadej, New-Delhi, Centre of South, Central, South-East Asian and South-West Pacific Studies, School of International Studies, Jawaharlal Nehru University.
- Connell, John 2006: Medical Tourism: Sea, Sun, sand and... surgery, in: *Tourism Management* 27, 1093-1100.
- Crooks, Valorie A./Leigh Turner/Jeremy Snyder/Rory Jonhston/Paul Kingsbury 2011: Promoting medical tourism to India: messages, images, and the marketing of international patient travel, in : *Social Science & Medicine* 72 (5), 726-732.
- Doheny, K. 2006, 'A little sightseeing, a little face-lift', *Los Angeles Times*, 29 January, 4

- Ellis, A.G 1936: The service to medicine in Siam: rendered by His Royal Highness Prince Mahidol of Songkla, in Ellis A.G. (ed.): *Contemporary History*, Bangkok: 165-198.
- Gesler, Wil 2005: Therapeutic landscapes: an evolving theme, in: *Health & Place* 11 (4), 295-298.
- Gesler, Wil/Morag Bell/Sarah Curtis/Phil Hubbard/Susan Francis 2004: Therapy by design: evaluating the UK hospital building program, in: *Health & Place*, 10 (2): 117-128.
- Glinos, Irene/Rita Baeten/Hans Maarse 2010: Purchasing health services abroad: practices of cross-border contracting and patient mobility in six European countries, in : *Health Policy* 95 (2), 103-112.
- Kearns, Robin A./J. Ross Barnett 1997: Consumerist ideology and the symbolic landscapes of private medicine, in: *Health and Place* 3(3), 171-180.
- Hours, Bernard/Monique Selim 1997: *Essai d'anthropologie politique sur le Laos contemporain: marché, socialisme et génies*, Paris, L'Harmattan.
- Ministry of Public Health, Thailand 2008: *Thailand Health Profile 2005-2007*, Bangkok, available online: <http://www.moph.go.th>.
- Mobillion, Virginie 2010: *Territoires et soins à Vientiane (Laos) : une géographie de la capitale d'une République Démocratique Populaire*, PhD Thesis in Geography, Paris Ouest Nanterre la Défense University, 486.
- Moorhead, Joanna 2004: Sun, sea, sand... and surgery, in: *The Guardian* May 11, 10
- Pachanee, Cha-aim/Suwit Wibulpolprasert 2006: Incoherent policies on universal coverage of health insurance and promotion of international trade in health services in Thailand', in: *Health Policy and Planning* 21 (4), 310-318.
- Pottier, Richard 2004: *Santé et Société au Laos (1973-1978). Le système de santé lao et ses possibilités de développement: le cas de la zone de santé de Tha Dña*, Paris, Comité de coopération avec le Laos (CCL), 505.

- Prince Mahidol Award Foundation 2002: In commemoration of the 110th Birth Anniversary of H.R.H. Prince Mahidol of Songkla, special publication in Bangkok Post, 7.
- Prince Mahidol Award Foundation 2007: In commemoration of the 115th Birth Anniversary of H.R.H. Prince Mahidol of Songkla, special publication in The Nation, 12.
- Robinson, William 1998 : Beyond Nation-State Paradigms: Globalization, sociology, and the Challenge of transnational Studies, in: Sociological Forum, 13 (4), 561-595.
- Saporta, Isabelle 2006: Les horreurs du tourisme médical, in: Marianne, 4 février, n°459.
- Somsack, Pongkhao 2007: "Health company to develop first private hospital", in: Vientiane Times, October 24, 5.
- Strigler, Florence/Bansa Oupathana/Jérôme Vandame/Jean-Pierre Deschamps 2005: La situation nutritionnelle et sanitaire et l'évolution du système de santé, in : Gentil, Dominique/Philippe Boumard (eds.), Le Laos, doux et amer, 25 ans de pratiques d'une ONG, Paris, Karthala, 115-132.
- Stuart-Fox, Martin 2006: The political culture of corruption in the Lao PDR, in Asian Studies Review, 30, 59-75.
- The Nation, 1996: "Non-Thais prove burden to border medical services", September 24, A7.
- Turner, Leigh 2012: Medical travel and the global health services marketplace: Identifying risks to patients, public health and health systems, in: Hodges, Jill R./Leigh Turner/Ann Marie Kimball (eds.): Risks and Challenges in Medical Tourism. Understanding the Global Market for Health Services, Santa Barbara, CA: Praeger, 253-278.
- Vaillant, Zoé/Gérard Salem 2008 : Atlas mondial de la santé. Quelles inégalités ? Quelle mondialisation ?, Paris, Autrement, 80.
- Wilson, Ara 2011: Foreign Bodies and National Scales: Medical Tourism in Thailand, in: Body and Society 17 (2&3), 121 – 137.

Bochaton: Thai hospitals at the crossroad of new patient flows

Xayxana, Leukai 2005: "Doctors say local hospitals give good service" in:
Vientiane Times, January 14, 3.

Holism as whole-body treatment.
The transnational production of Thai massage

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This article explores the role that transnational encounters played, and continue to play, in the social production of the whole-body form of Thai massage. After outlining the historical processes in the emergence of Thai traditional medicine and massage, the ethnography of a clinic in the city of Chiang Mai will help to understand how European and North-American people recently contributed to shaping this new form of bodywork. By interpreting Thai massage in terms of what they thought was yoga, foreign residents and travellers have led to the predominance of the whole-body style in massage, which gained currency among Thai urban middle class. On the other hand, the national authorities have standardized Thai massage as a remedy for ailments and/or symptoms affecting specific body parts. However, this article shows that between imagined holism and sensory specificity, the various shapes of contemporary Thai massage always echo the global trend in wholeness for “alternative therapies”. The author makes sense of this situation by using translocal and transnational analytic lenses to unpack the dynamics of a bodily practice deemed to be traditional.

The exponential increase of studies in Asian medicine has overlooked Thai massage, in spite of its global presence and increasing popularity. This article aims to fill this void. Originally a therapeutic form of bodywork⁶⁴ indicated for specific ailments, Thai massage became a whole-body technique in the last decades of the twentieth century, with an additional, sometimes dominant emphasis on relaxation, following a step-by-step routine from foot to head. Found in Thailand in public biomedical wards as one of the methods of Thai traditional medicine, as well as in private clinics, and spas targeting tourists, this most recent form of Thai massage has been produced through repeated series of translocal and transnational encounters. These social and cultural interactions reveal a set of complex exchanges, the product of which may be considered fluid and perpetually in the making. Just as Mei Zhan (2009: 1) has shown for Chinese medicine, Thai massage is made “through—rather than prior to—various translocal encounters and from discrepant locations”. The transnational production of bodywork does not only involve homogenization and deterritorialization (Appadurai 1996), but also recontextualization and “glocalization” (Robertson 1995), as global forms of knowledge are adapted to local circumstances and are transferred from locality to locality.

Several studies have been concerned with the transnational production of Asian bodywork among which yoga is a typical example. Elizabeth De Michelis (2005) has suggested that Modern Postural Yoga, those styles of yoga practice that put emphasis on *asanas* or postures, has been assimilated into bodywork in contemporary alternative medicine. Mark Singleton (2010) refers to such forms of yoga as “transnational anglophone yoga”, as they were formulated and transmitted in a dialogical relationship between India and the West through the medium of English. He has shown that the new yogic body is one that is

⁶⁴ This is a generic term that is used to define therapies that actually work on the body, such as osteopathy, massages, and even kinesiology. For definitions, see Jennifer Lea (2009: 465) and Julia Twigg (2000: 389).

thoroughly shaped by the practices and discourses of modern physical culture, “healthism”, and Western esotericism. What underlies this physical culture is a “harmonial” model of mind, body and spirit. Singleton notes that yoga has been affected by Western harmonial gymnastics, mainly based on stretching and balancing movements together with breathwork in order to gain “spiritual” relaxation (Singleton 2010). Invoking harmony and balance for health is also referred to in Sarah Strauss’ study of transnationally produced yoga (2005), through a process existing elsewhere, as with Indian ayurveda, that involves seeking for an “imagined Asian wholeness” (Langford 2002: 61). This article follows these studies, as it shows how postures and holism have come to be emphasized in the social production of Thai massage.

While this paper focuses on the contribution of European and North-American people in Thailand to build what is Thai massage today, I also use the term transnationalism, rather than globalism, to underscore the role also played by the nation. As Joseph Alter points out, “the uniqueness of transnationalism as a modern dynamic is primarily manifest in the way nationalism seeks to control culture” (Alter 2005: 14). Indeed, Thai authorities have set up national standards in Thai massage emphasizing its efficacy and safety as well as the continuity of the “royal tradition” – one of the most salient cultural expressions in the country.

On the other hand, Alter notes “the state is unable to fully control the body of the citizen in terms of medical knowledge and the production of knowledge by individuals” because “the embodied person is the ultimate object of medical treatment” (Alter 2005: 14). Then, how do individuals slip through or negotiate with transnational influences and state control? This article provides some elements in response by examining body techniques and sensory experiences in Thai massage, as a way to emerge from both the global influence of holism and the newly created national standard.

To this end, I first outline the historical construction of Thai traditional medicine and massage. This forms the background of my ethnographic study of a clinic and teaching centre in Northern Thailand. I show that the interpretation of Thai massage in terms of yoga (or what they thought was yoga) by students from Europe and North-America led, over the course of three decades, to the predominance of a whole-body style. This approach and practice also became very popular among Thai urban middle class. But there is a twist in the story: while the whole-body form dominates students' courses and, to a certain extent, clients'⁶⁵ expectations, the national authorities have standardized Thai massage, not in the whole-body form but as the remedy for specific symptoms and ailments affecting body parts, in an attempt to emphasize its efficacy and safety from the standpoint of biomedical science. This paper explores the tension between, and reconciliation of the imagined holism, the need to establish a national standard and the desire of individual healers who not only learn from their clients but also adapt to their demands. The transnational production of whole-body Thai massage ended in a fixed, institutionalized framework which, at the same time, gives ample room for individual improvisation, and therefore creation.

Historical outlines⁶⁶

Contrary to the popular discourse that views Thai massage as an ancient therapeutic technique dating from the time of the historical Buddha, the earliest textual materials on Thai traditional medicine date to the seventeenth century A.D.⁶⁷ For example, *Tamra Phra Osot Phra Narai (The Pharmacopoeia of King*

⁶⁵ I use the word "client" to account for the various people who receive Thai massage including both patients with specific symptoms and clients without them. In fact, the border between the former and the latter is blurred. For details, see Junko Iida (2006: 119-122).

⁶⁶ The description in this section overlaps with a part of my recent study (Iida 2010: 139-41).

⁶⁷ A record of *Sakdina* (a social hierarchy system in pre-modern Thailand) in mid-fifteenth century contains the rank of royal physicians (*mo luang*), including massage practitioners (*mo nuat*) (Prathip 1998: 28-9).

Narai), the oldest canonical text of Thai traditional medicine found thus far, was compiled in 1661 at a time when trade among Asian and European countries flourished in Ayutthaya (Somchintana 1986⁶⁸, Prathip 1998). The most famous historical sources of Thai massage instructions are the inscriptions and statues at Wat Pho, the royal temple in Bangkok. The inscriptions on the walls depict pressure points. Statues of hermits are posed in postures of therapeutic exercises, which are said to have influenced the stretching technique. These inscriptions and statues were constructed under the supervision of royal Thai physicians in 1832, a time when Thailand was significantly influenced by Western imperialism and Christian missionaries who helped introduce Western medicine to Thailand (Benja 1974: 9, Tambiah 1976: 204-13, Irvine 1982: 39, Prathip 1998: 91). Thai traditional medicine thus emerged alongside the region's encounter with the West and within the process of nation-building.

As the influence of Western medicine increased, traditional medicine became institutionally marginalized in Thailand. The use of traditional medicine was abolished at biomedical hospitals in 1915, and defined as a medical practice "without scientific foundation" by the law *Phrarachabanyat Khuapkhum Kanprakop Rok Sinlapa* (Act for the Control of the Practice of the Art of Healing) in 1936. Private institutions, established in urban areas, inherited Thai traditional medicine, including massage, and became centres of traditional practice. With the development of the sex and tourism industries in Thailand in the 1960s, however, "Thai traditional massage" began to be perceived as a tourist-oriented service and was often used as a cover for prostitution (Chantana 1989: 59-70). Since then, the phrase "Thai massage" has had ambiguous overtones relating to relaxation, tourism and sexual services.

⁶⁸ As in conventional usage, Thai names are referred to by their first names in the text and are entered in the list of references according to first names with full surnames after that.

However, stimulated by both the policies of the World Health Organization (WHO) and domestic traditional medicine revivalist movements since the late 1970s (Chantana 1989), the Thai government has begun to standardize Thai traditional medicine⁶⁹ and has been promoting Thai massage as one of its traditional therapies⁷⁰. As shown elsewhere by studies on traditional Chinese medicine in China (Hsu 1999) and Ayurveda in India (Langford 2002), the standardization of traditional medicine in Thailand has been conducted on the basis of nation-state ideology and was modelled after biomedicine. The making of this “tradition” followed the official monarchy-centred national history, and its efficacy and safety were, and still are, subject to biomedical scrutiny.

The licensing and educational system was also changed. In the licensing system for traditional doctors legislated in 1953, there were three kinds of licenses, namely medicine (*wetchakam*), pharmacy (*phesatchakam*) and midwifery (*phadungkhan*). The training time required was three years for medicine and one year each for pharmacy and midwifery. This system was criticized in the traditional medicine revivalist movements because there was no license for massage practitioners, and thus, it was insisted that this became an obstacle to professionalization. Based on this criticism, the Ministry of Public Health much later legislated new rules for massage in 2001. According to these rules, two years or 800 hours of training for certification are required to open a Thai massage clinic, 330 hours for an assistant to a traditional Thai doctor and 372 hours for practising at hospitals. In the 2000s, several universities established undergraduate and graduate programmes in Thai traditional medicines, although private schools continue to provide shorter courses.

⁶⁹ The phrase “Thai traditional medicine” is the official English translation for the Thai phrase “*kanphaet phaen thai*”, which literally means “Thai-style medicine”. The latter has been in use since the 1990s, replacing the old-fashioned term “*kanphaet phaen boran*” (“old/traditional style medicine”).

⁷⁰ For details, see Junko Iida (2005, 2006).

This change in health policy has gone hand in hand with the commercialization of Thai massage on a wider scale. Since the 1980s, Thai massage has become increasingly popular with foreign tourists. As the Thai urban middle class who are oriented towards “health” and “nature” increased in the late 1990s, the market of Thai massage for this group also widened. This has been influenced by the transnational circulation of the culture of “healthism”, as well as by a shift in the main causes of death in the urban areas of Thailand. From the causes associated by the WHO to “low-income countries” (malnutrition and infectious diseases) the pathological landscape in Thailand now increasingly involves what is called lifestyle diseases, such as cancer, cardiovascular disorders and diabetes (Komatra 1999: 8-9). As a “natural therapy” or as a pain-relief technique, Thai massage has gained popularity among the Thai urbanites as well as foreigners, and has become one of the growing areas in the health industry, which also includes herbal remedies, herbal cosmetics and health foods.

While in the past Thai massage has mainly been practised at private clinics and shops, it has also come to be practised at public biomedical institutions. According to the Chiang Mai Provincial Public Health Office, 25 district hospitals and 271 subdistrict health centres in the province were providing Thai massage services in 2009. It is there in Chiang Mai, the largest city in northern Thailand, that I conducted my research (from 1997 to 1999 and intermittently after that) in a clinic that offers both treatments and courses.

Travelling and learning

The Old Medicine Hospital (*Sathanphayaban Phaen Boran*)⁷¹ is a private clinic created in 1962. The clinic was founded by a man from Chiang Mai who studied

⁷¹ The formal name is *Sathanphayabaan Banthaothuk Boran Phak Nuea* (North Region Traditional Relief Clinic).

traditional medicine at Wat Pho, the royal temple in Bangkok. Until the 1970s, the Old Medicine Hospital employed various therapies including herbal remedies and magical treatments performed by local healers⁷². However, when the clinic's popularity declined in the 1980s, apparently because of the increase in the number of biomedical hospitals in Chiang Mai, it adopted Thai massage from Bangkok as a survival strategy. Today, the clinic offers Thai massage and herbal steam baths, as well as courses on Thai massage. It was the largest and one of the most well-known traditional therapy clinics in the northern region, and the massage course was the second most popular in Thailand, next to that of Wat Pho, in the late 1990s.

Initially, those who wanted to acquire the skills of Thai massage were apprenticed to practitioners. This changed in the mid-1980s, when the clinic established a standardized curriculum following an increase in the number of foreigners who wished to learn Thai massage. The course was open to both Thais and foreigners, regardless of whether the student wished to become a professional practitioner. In the 1990s, approximately 300 to 500 students enrolled in the ten-day, 60-hour course every year. The majority of the students were young tourists from Europe and North-America, although the number of Thai students increased at the end of 1990s, influenced by the government's policy and the commercial trends described above. At first, the classes were mainly delivered in English, but in the early 2000s, classes conducted in Thai were made available for Thai students who wished to learn through their own language. The curriculum has been constructed through the interaction between the clinic staff and the foreign students, with the purpose of enabling foreigners to learn Thai massage intensively in a short period.

⁷² For details on folk medicine, especially ethnobotany in northern Thailand, see Viggo Brun and Trond Schumacher (1994). Benja Yoddomnern and Walter Irvine also discuss the activities of this clinic in the 1960s and 1970s (Benja 1974: 19-28, Irvine 1982: 53-6).

Travelling to learn Thai massage

The majority of the students enrolled in the massage course at the Old Medicine Hospital consisted of people from Europe and North America. According to the founder of the Hospital, the first students included many Germans⁷³. In the late 1990s, however, Americans formed the largest group, followed by people from Western European countries such as the UK, Germany, France, Switzerland and Italy. Many people from Canada, Australia and Israel also came to learn Thai massage. A smaller number of students came from Asia, and among these, Japanese formed the largest proportion.

According to my interviews with foreign students, their motives varied from the wish to study “something Thai” during a holiday in Thailand to a professional interest. There were many people who were interested in “alternative medicine” or “Eastern medicine”. A German who learned shiatsu and reiki in India, a Greek couple who learned “Chinese massage” in the UK, an American massage practitioner from San Francisco who combined shiatsu and Swedish, Chinese and sport massages were among the students at the Old Medicine Hospital when I was carrying out fieldwork in 1998. Many of them were learning Thai massage to enrich their repertoire of therapies, and some were trying to create their own style of therapy.

Quite a few of the students practised yoga as well, and were quick to point out the similarity between yoga and Thai massage. Except for the breathing technique of yoga which is not included in Thai massage, some students reported feeling the similarity in terms of body technique while receiving Thai massage. A South African man of European origin, for example, even ended his course of Thai massage by assuming the *savasana* posture, which is often

⁷³ This might have been due to the influence of Asokananda and his book, described in detail later.

performed at the end of a yoga session. Thai practitioners often say that Europeans and North-Americans who practise yoga are similar to Thais in preferring a strong massage, whereas foreign clients in general prefer a softer form of massage (Iida 2010). In other words, the former group embodies the similarity between yoga and Thai massage. Thai massage is sometimes called “yoga for lazy people” –especially by foreigners– as a receiver can achieve postures similar to those found in yoga without moving their body for themselves.

Some Europeans and North-Americans expect “spirituality” in Thai massage. They regard this practice as a “spiritual practice” (Asokananda 1990: 8), along the lines of yoga and meditation. Many students first study yoga and meditation in India before travelling to Thailand to learn Thai massage. Richard Gold, who learned Thai massage at the Old Medicine Hospital, interprets it as a form of a meditative practice to attain spirituality (Gold 2000: 11). In fact, there are some Thai practitioners who also teach Thai massage to foreign people emphasizing spiritual aspects, but they do so, at least partly, in order to satisfy the expectations of foreign students.⁷⁴

Many people are attracted to Thai massage because of the fact that it deals with the whole body. A Dutch woman, for example, who practises homoeopathy and Swedish and Ayurvedic massage, said that she likes Thai massage as it treats not only the surface of the skin but also the whole body. A Japanese woman evaluated whole-body massage positively as she thought balance is important for the body. These discourses could be a reflection of the

⁷⁴ For a critical work on the “spiritualization” of traditional medicine as an answer to tourists’ expectations, see the work by Laurent Pordié in the Indian Himalayas (2011). There, practitioners of Tibetan medicine pragmatically attempt to create a space for communication with foreigners, but neither their medical knowledge nor their practice are deeply altered for all that. It is a form of “discursive mimesis” (p. 124), which, combined to the socio-political environment of the region and the learned Tibetan scholastic tradition linking medicine to Buddhism, accentuates the spiritual and Buddhist overtones of Tibetan medicine.

positive valuation given to the apparent “holism” and “balance” of Asian medicine as it is understood in the global context (Langford 2002, Pordié 2011).

Learning Thai massage to travel abroad

As Thai massage attracts interest around the world, it has come to act as a link between Thailand and foreign countries. Among the Thais who were learning Thai massage in the late 1990s, a large group consisted of those, mostly women, who were married to or were partners of European, North-American or Japanese people, and who were living in or planning to go to foreign countries. In my interviews, they explained that their reason for learning Thai massage is that it is a potentially useful and relatively easy to acquire skill for those who plan to go abroad, regardless of the possibility of working as practitioners. It required only ten days or sixty hours for finishing a course and receiving a certificate, and generally, between two weeks and one month for practising after taking the course before starting to treat clients. Although not all Thai people going abroad plan to practice Thai massage in their destinations, many of them think that it could be useful to acquire the popular skill of the “Thai traditional art of healing”.

Another group of Thai students consisted of those who wished to go abroad for work. There are a few Thais, including massage practitioners and teachers, who have gone abroad to practise or to teach Thai massage. For instance, a teacher who used to teach at the Old Medicine Hospital was invited to be a visiting instructor at the International Professional School of Bodywork in San Diego, California. During his six month stay, he learned Swedish, Chinese and Russian massage, shiatsu, tai qi and yoga. After coming back to Thailand, he founded a new school of Thai massage and yoga in Chiang Mai. It is also possible for those who are not teachers to go abroad if they are fortunate. For example, a woman who was married to a Thai of Chinese descent went to San

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Francisco in California. A cousin of her husband lived there, and was working with Thai massage practitioners who were married to American men. She came back to Thailand to learn Thai massage at the Old Medicine Hospital in order to return to San Francisco as a practitioner. Stories such as these make Thais who wish to go abroad think that Thai massage might be a way for them to make their wish come true. The Old Medicine Hospital, where students and clients from different countries come and go, also functions as an information centre for those who wish to go abroad.

Many “Eastern”-oriented Europeans and North-Americans and “foreign”-oriented Thais were learning Thai massage in the 1990s. This was one of the strategies embraced by Thai people that enabled them to benefit from foreigners’ Orientalist imaginations and expectations. In the 2000s, when Thai traditional medicine and massage gained more popularity among Thai urbanites as a result of the government policy and the commercialization trend mentioned earlier, a higher number of Thai people who were not necessarily “foreign”-oriented also came to be interested in learning massage. However, it was prior to that period when the form of whole-body massage was produced in the process of transnational encounters among these “Eastern”-oriented foreigners and “foreign”-oriented Thais.

Transnational production of Thai massage

Emphasis on Indian influence

Several foreigners published books and manuals of Thai massage after learning this technique at the Old Medicine Hospital (e.g. Asokananda 1990, Gold 2000, Otsuki 2002, Salguero 2004 and 2007). Among them, a key figure who introduced Thai massage into Western society was Asokananda (Harald Brust), a German national who wrote the first book on Thai massage in a Western

language in 1990⁷⁵. He was born in 1955 in then West Germany and studied community development. Since 1978 he regularly travelled to Asia, spending much time in India, Sri Lanka and Thailand. He was temporarily ordained as a Buddhist monk in Sri Lanka (Asokananda 1990). According to an interview I conducted with him in 1998, Asokananda learned yoga and meditation in Sri Lanka from an American Buddhist monk named Yogavacara Rahula⁷⁶, and moved to southern Thailand to teach yoga. Finding similarities between yoga and Thai massage, he moved to Chiang Mai in the mid-1980s to learn Thai massage at the Old Medicine Hospital. Once based in Chiang Mai, Asokananda taught Thai massage, yoga, tai qi chuan and meditation locally, as well as in Europe, North America, India, New Zealand and other countries. Asokananda passed away in 2005.

While the influence of Chinese acupuncture on Thai massage is sometimes mentioned (Salguero 2007: 62-66, Gold 2000: 14-18), the Indian origin is much more emphasized. Asokananda thus stressed the influence of Indian ayurveda⁷⁷ and particularly of yoga – as did other authors (Kasik 1997, Gold 2000, Salguero 2004, 2007). Some even refer to Thai traditional medicine as “Thai Ayurveda” (Salguero 2007) and Thai massage as “yoga massage” (Asokananda 1990) or “Thai yoga” (Salguero 2007). However, the extent of South Asian influence on Thai traditional medicine has been the subject of debate. There is a popular discourse that regards the founder of Thai traditional medicine as the legendary Chiwakakomaraphat⁷⁸, the personal physician of the historical Buddha over 2,500 years ago, and that assumes that Indian medical knowledge was

⁷⁵ His book *The Art of Traditional Thai Massage* was published in English, German, French and Italian.

⁷⁶ Yogavacara Rahula is the author of *One Night's Shelter: from Home to Homelessness: The Autobiography of an American Buddhist Monk* (Colombo: Public Trustee of Sri Lanka, 1985).

⁷⁷ He did so as a way to show that, in his understanding, Thai massage was not originally intended to be a part of prostitution but of healing (Asokananda 1990: 4-5).

⁷⁸ I have Romanized the Thai pronunciation, although in Indian context, it is spelled, Romanizing the Pali, as Jivaka Komarabhacca (Zysk 1998: 43) or Jivaka Kumar Bhaccha (Asokananda 1997: 4).

introduced with the diffusion of Buddhism to what is now Thailand. The basic principle of Thai traditional medicine written in Thai classical texts is also often compared to that of Ayurveda as it is based on an elemental model which analyses the health of an individual in relation to their balance of four elements, namely earth, water, air and fire. However, Jean Mulholland has pointed out that the passages based on Ayurveda in various textual sources “do not sit well within these texts”, and “seem to have been superimposed at the beginning or end of sections of an already established text” (Mulholland 1987: 226). The Thai medical tradition is often divided into two streams, namely the royal or “elite” tradition and the “common” or “folk” tradition, and it is the former that is referred to as having Indian influences. Viggo Brun and Trond Schumacher (1994: 30-33) argued that the theory of the Thai royal medical tradition was indeed imported from India, but was not integrated within the practice, functioning only as an ideal model. Pierce Salguero (2007: 94-95) suggests that the ayurvedic tradition, with its overarching theory and association with Buddhism and Brahmanic rituals, would have fit well with the nationalistic interest of the Chakri court.

With or without knowing this debate, Asokananda interpreted Thai massage has been intimately entangled with ayurveda and yoga, and his ideas attracted many Europeans and North-Americans. As a testament to his influence, some of the students at the Old Medicine Hospital said they came to learn Thai massage after reading Asokananda’s book. Thai massage was reinvented along the lines set by foreigners, and their convictions about its relationship with Ayurveda and yoga. Asokananda’s ideas and his book heavily affected the theory and practice of Thai massage.

Sen as “energy line”

Thai massage is applied along lines called *sen*. The location of *sen* is depicted in

the 60 diagrams inscribed on the walls of Wat Pho, and printed versions exist as well. The inscriptions on the walls indicate the location of each *sen*, the names of the “ten main *sen*” (*sen prathan thang sip*) and the effect of massage along each *sen*. Many writers note that these names of *sen* are derived from Sanskrit⁷⁹, and some of them share cognate names and similar locations with the *nadi* (or channels) of yoga. For example, Asokananda (1990: 6-7), Richard Gold (2000: 15-17) and Pierce Salguero (2007: 60-61) all maintain that *sen ithaa*, *pingkhalaa* and *sumanaa* correlate closely with *ida*, *pingala* and *sushumna nadi*. Asokananda regards *sen* as “the theoretical foundation of Thai massage” and translates the phrase into English as “energy line”. He thus wrote:

The Indian origin and influence become obvious here since the background of this theory clearly lies in yoga philosophy. Yoga philosophy states that life energy (called Prana) is absorbed with the air we breathe and with the food we eat. Along a network of energy lines, the Prana Nadis, the human being is then supplied with this vital energy... there are many lines and out of this multitude Thai massage has selected 10 mainlines on which there are especially important acupressure points.... These points can be thought of as “windows” into the body. These “windows” enable an exchange of cosmic energy through which the human body is maintained in an energy balance with the energy of the universe. Disturbances in the flow of energy result in an insufficient supply of Prana which will in turn lead to sickness. Working on the energy lines with massage can break the blockages, stimulate the free flow of Prana, and help to restore general well-being (Asokananda 1990: 6).

In spite of obvious misconceptions on yoga in this statement, Asokananda considers *sen* as being equivalent to “*prana nadi*”. The idea of invoking balance and harmony for health is predominant, as it is generally on modern

⁷⁹ The names of the ten main *sen* written in the printed version of the inscription on the walls of Wat Pho are *itha*, *pingkhala*, *sumana*, *kalathari*, *sahatsarangsi*, *tawari*, *janthaphusang*, *ruthang*, *sukumang*, and *sikini* (Rongrian Phaet Phaen Boran 1994 (1962): 2-19).

transnational yoga (De Michelis 2005 and Singleton 2010). The notion of Thai massage as bodywork for correcting energetic imbalances is a common understanding, often found in manuals (e.g. Salguero 2004: 178).

There are very few Thai practitioners who share this approach with Asokananda. For most Thai practitioners, *sen* is a part of the body that causes pain or stiffness when it is tensed or shifted out of alignment. In the “theory classes” of the massage course at the Old Medicine Hospital, however, the English phrase “energy line” is used to explain *sen* to foreign students – a discourse that encourage ethereal interpretations along the lines of Asokananda’s. Similar to what Elisabeth Hsu (1999) pointed out about the standardized educational systems of Traditional Chinese Medicine, the “theory class” at this school was started as a result of Western influence. The teacher, the elder son of the founder, said that he started the theory class in 1988 after graduating from the Ayurvedic College (*Rongrian Aayurawet Witthayalai*)⁸⁰ in Bangkok. At that time, students from abroad asked him to teach the theory of Thai massage, but he could not find any useful textbook. He did not think that the texts of the inscriptions on the walls at Wat Pho would be useful. Therefore, he said, he “thought up (the concept of “energy line”) by himself” while interacting with *farang* (the generic Thai term for “Western”) students who asked him to explain the meaning of *sen*. While it is not likely that Asokananda was included in these “*farang* students” (he learned Thai massage from another teacher who was delivering the course before the above-mentioned teacher came back from Bangkok), it is possible that this man did have some influence on the development of the notion of “energy lines”. Foreign students often exchange information with each other, and Asokananda’s work is very well

⁸⁰ The Ayurvedic College was not a college of South Asian ayurvedic medicine but a college of “applied Thai traditional medicine” (*kanphaet phaen thai baep prayuk*), which produced practitioners and public health personnel with basic knowledge of biomedicine as well as practical skills in traditional medicine (herbal and massage remedies). The college was incorporated in the Faculty of Medicine, Siriraj Hospital, Mahidol University, in the mid-2000s.

known among them. What counts for now is that *sen* came to be interpreted as “energy line” in the interactions between Thai teachers and foreign students.

The predominance of whole-body massage

Thai massage is provided in the form of a combination of point pressing and stretching techniques. As I have described above, the pressure points are said to be located along *sen*, and the stretching postures are regarded to be based on Thai “hermits’ exercise” (*ruesi datton*) represented by the statues in Wat Pho. Many people find similarities between the postures in yoga and the stretching techniques in Thai massage (e.g. Asokananda 1990: 9, Salguero 2004, 2007: 58). It is likely that the spread of “Modern Postural Yoga” has affected the popularity of Thai massage in the West.

Although basic Thai massage is currently provided in the form of whole-body massage, following a step-by-step routine from foot to head, in the past massage aimed to provide a targeted treatment for a specific body part related to the specific symptoms experienced by each client, similar to the massage still practised by rural villagers today (Iida 2006). While it is not clear when and who initiated the practice of whole-body massage, the teacher at the Old Medicine Hospital said that it was developed to satisfy the needs of foreign tourists who reported having no specific symptoms or disorder. Despite the claim that Thai massage was not originally a part of the hospitality industry but of healing, tourism has played an important role in the production of whole-body Thai massage. And Asokananda made a significant contribution to the development of the whole-body massage approach. Lea (2009: 468) describes it as follows:

Asokananda shaped TYM [Thai Yoga Massage] as a body of practice, effectively “packaging” a nebulous and experimental set of movements into a

more “logical” form. The moves were named in English, mapped through specific configurations of bodies, and stabilised through the attribution of specific therapeutic effects to particular moves. Asokananda’s sequence means that performing one technique makes the following one more effective, or easier to give or receive.

However, while Asokananda certainly had an instrumental role, numerous other Western people also contributed to the rise of the whole-body massage approach. The textbook used in the practice classes in the massage course at the Old Medicine Hospital was based on manuals compiled by foreign students. Among those who came from abroad in the late 1980s to learn massage at the Hospital, some dealt with the lack of textbooks by making manuals for themselves. Some of these handmade manuals were photocopied and distributed to the rest of the students. I saw such textbooks in progress at the Hospital when I was conducting fieldwork there in 1998. They were paperbound and contained pictures and explanations. There were French, German and English versions and they had been revised many times. In an English manual, the author wrote:

This manual contains supplements, rearrangements and clarifications of an earlier manual. Its aim is to aid the “farong” [meaning *farang*] student to a better overall understanding of Thai massage... bridging the cross-cultural differences between the Thai-style of teaching and the western style of learning (Heyden n.d.: 1) During the course, you will come to the realization that there are “many, many” techniques and styles which vary from masseu(r)se to masseu(r)se. This section is a conglomeration of the techniques taught while I was attending the course and from what was in the earlier manual (Heyden n.d.: 16).

Thai massage technique being taught at that time was not fully standardized, and foreign students were actively revising their manuals by adding in new materials covering techniques not addressed in earlier versions. Teachers at the Hospital said that the Thai staff also contributed to the revision process, sometimes helping to simplify the complicated parts. The founder of the Hospital said in 1998 that they had revised the “textbook” 20 or 30 times already and that they would continue to do so. It seems that the bulk of the material documenting the Thai massage course was compiled quite early, as the course started in the mid-1980s and the manual made in 1990 appears to be very similar to the textbook in use today.

In the current textbook, there are about 100 diagrams illustrating the sequence of whole-body massage. The diagrams show the pressure points and lines, as well as the postures of the giver and receiver of the massage, with blank spaces on the side for taking notes. During the practice class the teacher demonstrates standardized techniques and explains how to give massage according to the textbook, and students take notes. When I took the course, I found the explanations to be very precise. For example, the teacher explained how many degrees the giver bends the receiver’s arm and which part of the body the giver presses and with which finger of which hand, for how many seconds and how many times. The teacher at that time was the younger son of the founder. He said that he learned the right words to use in English in order to explain each step from the manuals made by past foreign students. After the demonstration and explanation of each section, students practise what they have learned with the aid of the diagrams and notes they took. Students must submit assignments everyday and pass examinations in both theory and practice for earning the certificate.

Thai massage attracted the interest of Europeans who found it to be similar to yoga, and the theory and practice of Thai massage were shaped by the

process of interaction between Thai practitioners and Western students. In that process, just as in the transnational production of yoga, postures and the notion of balance have come to be emphasized. The need to satisfy tourists without specific ailments and/or symptoms was also one of the factors in the production of the whole-body style of massage.

Standardization and improvisation

Not only foreigners but also Thai people, especially members of the middle class, embrace receiving Thai massage today. In this section, I will examine the influence of the transnational production of Thai massage on its national standardization and practice.

National standard of Thai massage

The Thai government has been standardizing the components of Thai traditional medicine, including Thai massage. The National Institute of Thai Traditional Medicine, which was established by the Ministry of Public Health in 1993 and was reorganized as the Department for the Development of Thai Traditional and Alternative Medicine in 2003, co-ordinated this project. Knowledge concerning Thai massage has been standardized mainly on the basis of the nation-state ideology, essentially following the biomedical model⁸¹. The Institute published several textbooks and manuals on Thai massage. They were compiled mainly by teachers and graduates of the Ayurvedic College presented above, and thus combined biomedical diagnoses and massage therapy.

⁸¹ In this process, however, the Institute conducted research on other varieties of Asian medicine, especially Ayurveda and traditional Chinese medicine, to examine the safety and efficacy of the therapies (Sathaban Kanphaet Phaen Thai 1994). It even incorporated some part of yoga, Chinese foot massage and acupuncture into Thai traditional medicine.

In these texts, there are explanations on basic knowledge of anatomy, pressure points along the ten main *sen* as inscribed on the walls of Wat Pho, and methods of massage depending on the reported symptoms and problems. In the inscription on the walls at Wat Pho, there is no definition or explanation of what *sen* is. In contrast, *sen* is objectified as a folk concept in these texts. The short explanation of *sen* in the textbook titled *Lines, Points and Sickness in the Theory of Thai Massage (Sen Jut Lae Rok nai Tharitsadi Kannuat Thai)* reads: "According to a past belief, *sen* is a pipe in which wind and blood flow. Concentration of blood and wind at a point causes pain. If blood and wind flow well, one can be healthy" (Pennapa 1995: 22, my translation). It is also noteworthy here that the explanation is based on the notion of imbalance as a cause of pain. The list of references in this textbook contains Asokananda's book, although his explanation on *sen* is different from this explanation. In the manual *Thai Massage for Health (Kannuat Thai phuea Sukkhaphap)*, *sen* is explained in terms of "energy" (although this interpretation also differs from Asokananda's):

According to Thai traditional medicine, the movement of each body part is the energy (*phalang*) of wind, which might refer to the nervous system or the lymphatic system, although this view is not accepted by modern medicine. In Thai traditional medicine, the energy of the movement of wind occurs along *sen* lines (Sathaban Kanphaet Phaen Thai 1997: 13, my translation).

To my knowledge, this is the first explanation of *sen* using the concept of "energy" in written Thai texts. Although it is not clear which sources the author is actually referring to, there might have been influences reflecting ideas of "energy lines" described earlier. What is more salient here, however, is that the author is trying to explain the concept of *sen* using biomedical terminology.

Indeed, one can see the effort to verify the validity of folk knowledge and the efficacy of Thai massage from a biomedical perspective in these textbooks. In *Lines, Points and Sickness in the Theory of Thai Massage*, for example, pressure points along *sen* are indicated on anatomical figures of the body. Explanations of the symptoms that can be relieved by massage in these texts contain biomedical terms such as migraine. In the national standard, “hermits’ exercise” (*ruesi datton*) is not included, but is treated as a separate health care practice. Standard massage techniques consist mostly of point pressing by fingers, and many stretching techniques have been eliminated. This is firstly because certain techniques were considered to be dangerous according to biomedical criteria, and secondly because the massage adopted by the Ayurvedic College is called “royal style massage” (*kannuat baep ratchasamnak*), which use only the finger tips, eliminating techniques that use elbows, knees and feet from “people’s style massage” (*kannuat baep chaloeyasak*) to be applied for members of the royal family.

Whole-body massage as a healthcare option

The government has thus been trying to standardize Thai massage as a scientifically validated therapeutic technique. Although one can find some influences of the transnational trend on some concepts including balance and energy in the texts described above, nationally standardized Thai massage does not involve the whole-body form, but stands as a remedy applied for specific parts of the body according to ailments and symptoms. Despite the efforts of the government, the whole-body form of massage including stretching is practised today as the standard style of Thai massage for not only foreigners but also Thais. In an interview conducted at the Old Medicine Hospital in 2007, quite a few Thai clients said that they value Thai massage because it treats the whole body. Indeed, these clients are so familiar with the course of treatment that they know if a practitioner has skipped a step, and sometimes tell them so. Practitioners are expected to provide whole-body massage, unless the client has

a specific problem that needs particular attention. Therefore, beginners typically seek to memorize the sequence of whole-body massage, although the sequences and techniques are slightly different among schools and individuals.

This trend is related to Thai people's varying reasons for receiving massage treatment. As mentioned earlier, the whole-body form of massage was originally developed to satisfy the needs of foreign tourists who desired treatment but had no specific problems. Today, increasing number of people from Thailand appreciate whole-body massage for relaxation rather than as a form of therapy. The border between relaxation and therapy is blurred, but the fact is that more people receive Thai massage for stiffness of the whole body, for example, than for a specific problem in a body part. Many Thai urban middle-class say that they take massage in order to relax from "stress" (*khriat*), adopting a blurred biomedical concept. Some of them say that yoga is another option for relaxation.

Practices emerging from the standard

Is Thai massage treatment therapeutic at all? It is sometimes provided for those who have specific symptoms and ailments, but that kind of treatment differs from the whole-body massage described thus far. Jennifer Lea notes that the standardization of the technique and the educational system has removed the "spiritual" and "psychic" aspects of Thai massage, including intuitive diagnostic sensitivity developed by an apprenticeship style of learning. While Lea's research focuses on the UK context, she mentions the possibility of the same tendency in Thai massage in Thailand (Lea 2009: 468). It is partly true, but Thai massage practitioners still acquire such sensitivity outside of the curriculum at school.

Those wishing to become massage therapists practice massage with qualified therapists for between two weeks and one month after finishing the course at the Old Medicine Hospital. During this period, a beginner practices giving adequate pressure to the correct points on the body by giving massage to a senior practitioner. *Sen* vary slightly from person to person and thus no matter how precise an explanation is given in the classroom, teachers say that it is ultimately from practice and each individual's own sense of touch that he or she learns exactly how to work on the *sen*. This period of supervised practice gives learners the opportunity to gain the important tactile experience needed to locate the correct points [*thuk sen*] (Iida 2010: 143-146).

Practitioners also develop their skills through interaction with clients. Most foreign clients have no physical ailments or symptoms, and it is difficult for massage practitioners to communicate verbally with them. Therefore, massage for foreigners is primarily provided in the form of the "course" of the whole-body massage without much rearrangement. In contrast, at the beginning of a treatment for a Thai client, a practitioner usually asks what symptoms or requests he or she has, and arranges the two-hour course of whole-body massage following these requests. A practitioner spends more time on the steps related to the concerned body area, and thereby omits some of other steps of the whole-body massage. If a client has a symptom, a practitioner needs to find the *sen* which is "tense" [*tueng*]. A tense *sen*, the cause of pain, is stiff [*khaeng*] or sometimes has a lump [*pen kon*] when touched. This tension and pain can only be alleviated when the *sen* is relaxed. Massage practitioners combine verbal and tactile communication to identify which *sen* to focus on. Touching the stiff *sen*, a practitioner often asks a client if he or she feels pain; sometimes this information is offered by the client without being asked. A practitioner touches the *sen* not only to find out if it is tense but also to "make it relax" [*khlai*]. A practitioner's touch is thus both passive and active in the sense that it works as a diagnostic and a healing tool. Particularly for clients who have serious

problems, neither whole-body massage nor stretching is applied. Instead, practitioners concentrate on finger pressing along the *sen* related to the symptoms. This kind of therapeutic massage for specific ailments and symptoms is called “to cure the *sen*” [*kae sen*]. An ailment cannot necessarily be healed with only one treatment. A practitioner often asks a patient with a problem to re-visit and, if the therapy is not effective, he or she tries another therapy the next time. Even experienced practitioners discover how to treat their patients through trial and error throughout the course of the treatment. The treatment is thus a learning process for the practitioner. As a single form of therapy cannot be applied to all patients with similar ailments, there is a limit to what senior practitioners can teach beginners. Beginners therefore develop their skills through trial and error, while answering clients’ various requests (Iida 2010: 147-149).

Even though a treatment is apparently provided in the form of whole-body massage, treatment for clients with specific problems focuses on the involved body parts. Stretching techniques are eliminated, not by anatomical knowledge or etiquette but by the practitioner’s experiential knowledge acquired mainly through the sensory experience of interaction with clients. The practice of Thai massage thus sometimes appears to stand at odds with the whole-body practice promoted by foreigners, while at the same time being inscribed in the very whole-body massage format. It does not follow the nationally standardized “scientific” therapy and “royal tradition” either, although it focuses on the finger pressing for the treatment of specific problems of particular body parts.

Conclusion

The whole-body form of Thai massage has been produced through transnational encounters among “Eastern”-oriented Europeans and North-Americans, who found similarities between Thai massage and yoga, “foreign”-

oriented Thais, who aimed to benefit from foreigners' Orientalist imaginations and expectations, and the Thai urban middle class, who have been influenced by the globalizing culture of healthism. Individual bodily practice, however, sometimes emerges from the trend and focuses on specific body parts, depending on the symptoms and requests of the individual client, while following the apparent whole-body style of massage.

In transnational encounters, Thai massage as well as other Asian forms of healthcare, including yoga, have been imagined, expected and standardized as holistic healthcare practices that invoke balance and harmony. This holism is "bodily holism", in which different body parts are viewed as being connected (Adams 2002: 253). Holistic healthcare practice, however, does not necessarily equal whole-body treatment. Furthermore, while the whole-body form of Thai massage is applied for all clients, interaction with each client produce therapeutic massage that barely follows the standardized form. Between this imagined holism and sensory specificity, transnational encounters produce varying forms of Thai massage, even though they are still embedded in the whole-body framework.

This article has suggested the importance of the attention to body and the sensory experience in the exploration of transnational health care. Transnational encounters, especially in the area of health care, involve interactions between people with different bodily and sensory experiences situated in various social and cultural contexts. It is not only ideas such as healthism, holism and balance, but also the practice of whole-body massage, improvisation and the feeling of pain that produce Thai massage today. While the body is culturally and socially embedded, it also has an emergent and contingent nature. This duality echoes, or might even be the foundation of both the bounded and open-ended aspects of transnational actions discussed in transnational studies. Luis Eduardo Guarnizo and Michael Peter Smith suggested that transnational actions are

doubly bounded by “‘grounded reality’ socially constructed within the transnational networks that people form and move through” and by the policies and practices of territorially-based local and national states and communities (Guarnizo and Smith 1999). On the other hand, Anna Tsing used the word “friction” to stress uncertain processes and outcomes of global connections (Tsing 2005). These are two aspects of the same reality. The production of whole-body Thai massage are bounded by the transnational networks of people influenced by globalizing culture of “healthism”, and by the policies of WHO as well as the Thai government. However, even though individual practice basically follows the whole-body style, concrete bodily interactions also have potentials to produce creativity and diversity.

References

- Adams, Glyn 2002: Shiatsu in Britain and Japan. Personhood, Holism and Embodied Aesthetics, in: *Anthropology & Medicine* 9(3), 245-65.
- Alter, Joseph S. 2005: Introduction: The Politics of Culture and Medicine, in: Alter, J. S. (ed.): *Asian Medicine and Globalization*. Philadelphia: University of Pennsylvania Press, 1-20.
- Appadurai, Arjun 1996: *Modernity at Large: Cultural Dimensions of Globalization*, Minneapolis/London: University of Minnesota Press.
- Asokananda (Brust, Harald) 1990: *The Art of Traditional Thai Massage*. 6th edition, Bangkok: Editions Duang Kamol.
- Benja Yoddumnern 1974: *The Role of Thai Traditional Doctors*, Bangkok: Institute for Population and Social Research, Mahidol University.
- Brun, Viggo/Trond Schumacher 1994: *Traditional Herbal Medicine in Northern Thailand*, Bangkok: White Lotus.
- Chantana Banpasirichote 1989: *The Indigenization of Development Process in Thailand: A Case Study of the Traditional Medical Revivalist Movement (Thai Massage)*, Ph.D. Thesis, University of Waterloo.
- De Michelis, Elizabeth 2005: *A History of Modern Yoga: Patanjali and Western Esotericism*, London/New York: Continuum.
- Gold, Richard 2000 (1998): *Taishiki Massaji: Tai Dento Iryo no Riron to Tekunikku*, Kanagawa: Ido-no-Nippon-Sha. (Thai Massage: A Traditional Medical Technique, Oxford: Churchill Livingstone.) (In Japanese)
- Guarnizo, Luis Eduardo/Michael Peter Smith 1999: The Locations of Transnationalism, in: Smith, Michael P./Luis E. Guarnizo (eds.): *Transnationalism from Below*. New Brunswick/London: Transaction Publishers, 3-34.

- Heyden, Mary n. d. Written Manual Accompanying the 10-day Basic Thai Massage Course at the Foundation of Shivaga Komarapaj, Old Chiang Mai Traditional Hospital.
- Hsu, Elisabeth 1999: *The Transmission of Chinese Medicine*, Cambridge: Cambridge University Press.
- Iida, Junko 2005: *The "Revival" of Thai Traditional Medicine and Local Practice: Villagers' Reaction to the Promotion of Thai Massage in Northern Thailand*. Paper presented at the 9th International Conference on Thai Studies, Northern Illinois University, DeKalb, Illinois, 3-5 April 2005.
- Iida, Junko 2006: *Tai Massaji no Minzokushi: "Tai-shiki Iryo" Seisei Katei ni okeru Shintai to Jissen (Ethnography of Thai Massage: Body and Practice in the Process of the Creation of "Thai Traditional Medicine")*, Tokyo: Akashi Shoten. (In Japanese)
- Iida, Junko 2010: *The Sensory Experience of Thai Massage: Commercialization, Globalization, and Tactility*, in: Kalekin-Fishman, Devorah/Kelvin E. Y. Low (eds.): *Everyday Life in Asia. Social Perspectives on the Senses*, Surrey: Ashgate, 139-56.
- Irvine, Walter 1982: *The Thai-Yuan "Madman" and the "Modernizing, Developing Thai Nation" as Bounded Entities under Threat: A Study in the Replication of a Single Image*, Ph.D. Thesis, SOAS, University of London.
- Kasik, Heinz 1997: *Sen Massage: The Traditional Thai Massage Instructed by Wat Po (Wat Pra Chetuphon)*.
- Komatra Chuengsatiansup 1999: *Alternative Health, Alternative Sphere of Autonomy: Cheewajit and the Emergence of a Critical Public of Thailand*. Paper presented at the 7th International Conference on Thai Studies, IIAS and University of Amsterdam, The Netherlands, 4-8 July 1999.
- Langford, Jean M. 2002: *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*, Durham, NC: Duke University Press.

- Lea, Jennifer 2009: Becoming Skilled. The Cultural and Corporeal Geographies of Teaching and Learning Thai Yoga Massage, in: *Geoforum* 40, 465-74.
- Mulholland, Jean 1987: Ayurveda, Congenital Disease and Birthdays in Thai Traditional Medicine, in: *Proceedings of the International Conference on Thai Studies*, The Australian National University, Canberra, 3-6 July, 225-30.
- Otsuki, Kazuhiro 2002: *Hohoemi no Kuni karano Okurimono (A Gift from the Land of Smile): Thai Massage*, Tokyo: BAB Japan. (In Japanese)
- Pennapa Subcharoen 1995: *Sen Jut lae Rok nai Tharitsadi Kannuat Thai (Lines, Points and Sickness in the Theory of Thai Massage)*, Bangkok: Rongphim Ongkan Songkhro Thahan Phan Suek. (In Thai)
- Pordié, Laurent 2011: Accentuations et pragmatisme. Le savoir médical tibétain à destination des étrangers, in: *Revue d'Anthropologie des Connaissances*, 5(1) : 99-130.
- Prathip Chumphon 1998: *Prawattisat Kanphaet Phaen Thai: Kansueksa jak Eekasan Tamra Ya (History of Thai Traditional Medicine: A Study from Pharmacopoeia Documents)*, Bangkok: Akhithai. (In Thai)
- Robertson, Roland 1995: Glocalization: Time-Space and Homogeneity-Heterogeneity, in: Featherstone, Mike/Scott Lash/Roland Robertson (eds.): *Global Modernities*, London: Sage, 25-44.
- Rongrian Phaet Phaen Boran 1994 (1962): *Tamra Ya Sila Jaruek nai Wat Phrachetuphonwimonmangkharam (Wat Pho) Phranakhon. (Traditional Medical School, Pharmacopoeia of Inscription in Wat Pho. In Thai)*
- Salguero, C. Pierce 2004: *Encyclopedia of Thai Massage: A Complete Guide to Traditional Thai Massage Therapy and Acupressure*, Chiang Mai: Silkworm Books.
- Salguero, C. Pierce 2007: *Traditional Thai Medicine: Buddhism, Animism, Ayurveda*, Prescott, AZ: Hohm Press.

- Sathaban Kanphaet Phaen Thai 1994: Sathaban Kanphaet Phaen Thai (National Institute of Thai Traditional Medicine), Ministry of Public Health. (In Thai)
- Sathaban Kanphaet Phaen Thai 1997: Kannuat Thai phuea Sukkhaphap (Thai Massage for Health), Bangkok: Sathaban Kanphaet Phaen Thai. (In Thai)
- Singleton, Mark 2010: *Yoga Body: The Origins of Modern Posture Practice*, Oxford: Oxford University Press.
- Somchintana Thongthew Ratarasarn 1986: *The Principles and Concepts of Thai Classical Medicine*. Ph.D. Thesis, University of Wisconsin.
- Strauss, Sarah 2005: *Positioning Yoga: Balancing Acts Across Cultures*, Oxford: Berg.
- Tambiah, Stanley J. 1976: *World Conqueror and World Renouncer: A Study of Buddhism and Polity in Thailand against a Historical Background*, Cambridge: Cambridge University Press.
- Tsing, Anna L. 2005: *Friction: An Ethnography of Global Connection*, Princeton/Oxford: Princeton University Press.
- Twigg, Julia 2000: Carework as Bodywork, *Ageing and Society* 20, 389-411.
- Zhan, Mei 2009: *Other-Worldly: Making Chinese Medicine through Transnational Frames*, Durham, NC: Duke University Press.
- Zysk, Kenneth G. 1998: *Asceticism and Healing in Ancient India: Medicine in the Buddhist Monastery*, Delhi: Motilal Banarsidass.

From lineage transmission to transnational distance education:
The case of siddha varmam medicine

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Studies on transnational healthcare tend to focus on the flows of institutions, practices and people rather than on the flow of knowledge. This article seeks to fill this gap by exploring the modes of instruction in siddha medicine and, in particular, varmam or “vital spot” manipulations. It compares the instruction of hereditary practitioners in South India and their intimate, long-term learning relationship to that of a newly established learning course which aims to attract foreign students and provides lessons and exams by e-mail. While the former mode employs tactile techniques, the latter is largely based on the transference of textual knowledge. The article recognizes modalities of knowledge transmission, intentions of teachers, and perceptions of students as important sites for the study of therapeutic transnationalism. Entrepreneurial forces are a key element, but have hitherto rarely been acknowledged as such with regard to siddha medicine. This article finally shows that not only Asian medicines but also their transnational means of instruction have become marketable commodities.

Transnational studies focus on global movements, transport, and flows; they study diasporic communities, migratory flows, or again multilateral institutions (Castells 1996; Dolby and Cornbleth 2001: 294). The main site of analysis concerns nation-state borders and the various agencies that cross them, defining the meaning of transnational as “extending beyond loyalties that connect to any specific place of origin or ethnic or national group” (Waldinger and Fitzgerald 2004: 1178). In the case of Asian medicines, this has been described as a “dialectic process that involves regional and local appropriations, which results in Asian medicines becoming knowledge and practice streams that are distinct from those in their country of origin” (Høg and Hsu 2002: 210). Movements of both caregivers and people seeking care in transnational frameworks have been analyzed to understand underlying motivations, related impacts, and the actions of both governments and public forces in the healthcare sector, together with accompanying transformations of practices.

Despite a growing body of literature on transnational Asian healthcare and the circulation of therapeutic practices, there is, in my opinion, acute demand for research which seeks to understand the transmission of medical knowledge and its transnational spread. While a considerable amount of research has been conducted on transnational healthcare, the majority of these studies have focused on the flow of practices to the neglect of the flow of knowledge, which is essential to the process of transnationalizing medical practices. This paper seeks to redress this scholarly oversight by focusing on siddha medicine of Tamil South India in general and on *varmam*, the “vital spots,” in particular. It shows that modes of medical instruction are central to the translation and transformations that are often argued to accompany the transnationalization of Asian healthcare practices. One aspect of this involves highlighting the instrumentality of an evolving platform for knowledge transmission—in the present case, the Internet—in influencing what is being transmitted and how.

Soon after the terms globalization and transnationalism had been introduced into academic publications, conflicts arose over whether such processes of “transformation in the spatial organization of social relations and transactions (...)” (Held 1999: 16) entailed homogenization or heterogenization of practices worldwide (Høg and Hsu 2002: 205). Roland Robertson’s popular study (1995) suggested the term “glocalization,” as a compromise to the debate. According to Robertson, this neologism constitutes the transfer of a cultural product or practice from one locality to another, thereby being re-shaped accordingly when introduced into a new locality. In this manner, some scholars perceive instances of glocalizations of Asian healthcare as the spread of technology and the transfer of knowledge and practice streams from the East to the West and back, assuming that (re-)adjustments of such commodities and practices are being conducted within new settings—upon transfer—in a recipient culture (Adams 2002: 248; Høg and Hsu 2002: 212). This paper shows otherwise. There are, for example, many instances of transnational settings located in the original culture of a given medical practice which bring about transformation and facilitate global circulation (Pordié 2011; 2012). By highlighting the modifications carried out in the case of *varmam* therapies through comparing hereditarily transmitted forms with recently evolving distance education opportunities, that is, an Internet-based diploma course, this paper identifies multiple factors as requiring consideration in order to understand the transnationalization of healthcare. In the case of *varmam* therapy, this includes the modalities of knowledge transmission, the intentions of teachers, and the perceptions of students—all of which are important sites for the study of therapeutic transnationalism. Moreover, modifications and translations of knowledge and practice streams do not exclusively or entirely happen upon transfer into a different setting, but may be a necessity for their transnational transfer.⁸² I argue that translations of knowledge in a transnational setting can

⁸² In the case of Ayurvedic pharmaceutical production and the reformulation of drugs for the global market, see the work by Pordié and Gaudillière (in press).

only be acknowledged by recognizing the agencies of teachers and students— agencies, which previous studies on transnational healthcare, though struggling to recognize the agencies of patients, practitioners, and of institutions in the processes of the global spread of practices— have neglected.

By analyzing both the hereditary mode of *varmam* instruction and the distance education modalities, I will argue that along with medicine and medical practices knowledge too must be seen as a valuable market commodity. Both Asian medicines and the knowledge and education surrounding them have become marketable. This holds true for siddha medicine as well, which needs to be examined as a market commodity from the perspective of entrepreneurial forces, but which, with only few exceptions, has been largely explored in regard to Tamil nationalist promotional strategies.

Siddha, varmam spots, and hereditary knowledge transmission

Siddha medicine is one of the indigenous, codified medicines of India. It is closely related to ayurveda in theoretical content and therapeutic application, but deviates in being practiced mostly in the South Indian state of Tamil Nadu as well as in other countries, such as Sri Lanka and Malaysia, which are home to considerable Tamil populations. Although recognized and patronized by the Ministry of Health and Family Welfare of India, siddha clearly lags behind the better known ayurveda with regard to standardization, institutionalization and promotion. There are comparatively less professionalized practitioners than non-institutionally trained ones and fewer manufacturers of siddha than ayurvedic medicine for the domestic and the global markets.

Heightened interest in siddha is a recent phenomenon, however, and the differences between ayurveda and siddha can be drawn only from when they began to be documented in the beginning of the twentieth century (Hausman

1996). Earlier, these medicines were not strictly delineated by physicians or within the medical compendia (Krishnamurthy 1984). Scholars have therefore asserted that the promotion and institutionalization of siddha was influenced by Tamil language revivalist rhetoric and its proponents, which argue that siddha medicine is a medical science in its own right and independent from ayurveda (Weiss 2003; 2009). However, research on siddha remains scarce.⁸³ Brigitte Sébastia (2011) has produced the only piece of scholarship appraising this medicine's transnational impact and some of its entrepreneurial efforts. In line with this work, I intend to show here that siddha medicine as promoted and instructed transnationally may not necessarily be connected to a Tamil revivalist agenda.

The practices which are at the center of this paper are called *varmam*. Most *varmam* practitioners live in the southernmost part of South India, in Kanyakumari district, where they are known as *varma ācāṅs*. They are primarily hereditary practitioners, knowledgeable of *varmam* spots: a set of vulnerable loci of the body which, when afflicted—by physical trauma for instance—cause severe health problems and may lead to death. Such loci are central to siddha therapeutic and martial practices, which together are called *varmakalai*, literally the “art of the vital spots.” Thus *varmam* apply to combative activities and possess therapeutic value. Practitioners learn to protect their own and to target an opponent's loci in a practice called *varma aṭi*, literally: “hitting the vital spots.” Medical treatments, or *varma maruttuvam*, “vital spot medicine,” include massages, setting of fractures, and emergency revival methods. Practitioners perform both medical and martial aspects of *varmam* side by side, which, rather than contradict each other, mutually enhance physical exploration and experiences of the body and lead to an in-depth understanding of vital loci.

⁸³ Among the handful of specialized works, see Weiss (2003; 2009), Hausman (1996), Daniel (1984), Sujatha (2009) and Sébastia (2010; 2011).

Varmam is understood as a sub-discipline of siddha medicine, and thus falls under the education policies of AYUSH, a central government department which states to provide “focused attention to development of Education & Research in Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy systems.”⁸⁴ Education facilities under AYUSH tutelage include siddha medical colleges, which recognize *varmam* as an intrinsic component of siddha. Their official curriculum includes “Varmam and Thokkanam (massage).” However, hereditary practitioners, students, and some college lecturers contest this. Many students complained to me that *varmam* is either not part of their instruction at all, because of their teachers’ ignorance of vital spots, or that it is only available to post-graduate students who are required to visit regularly the dispensary of one or several hereditary practitioners to seek instruction from them.

These hereditary practitioners, *varma ācāns*, generally despise the “book knowledge” (*nūlarivu*) of siddha colleges, claiming that it provides theoretical but not practical knowledge. Many predict the failure to teach *varmam* in siddha medical colleges based on these assumptions. According to them, a student best learns by working hands on in a close-kin relationship with an accomplished practitioner. *Varmam* manuscripts, even those in the form of palm-leaf scriptures, insist that accepting a practitioner as one’s *guru* and living in a close, intimate relationship with him are key components of siddha instruction. Throughout South Asia similar modes of education—called *guru-śiṣya-paramparā*: transmission of knowledge via the lineage (*paramparā*) of preceptor (*guru*) and student (*śiṣya*)—are commonly used to instruct students in various skills and eruditions. This includes living with, observing and assisting a practitioner. *Varmam* manuscripts stipulate twelve years of instruction, a period described by practitioners as difficult (*kaṣṭam*) and testing (*cōtanai*) in

⁸⁴ See <http://indianmedicine.nic.in/background.asp> (last consulted on 05.07.2012). The Department of AYUSH was created 1995 under the name of Department of Indian Systems of Medicine and Homeopathy (ISM&H) and re-named as Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in November 2003.

retrospection. Indeed, in order to learn *varmam*, some practitioners state, it is necessary to test a student's ability and mind-set before he or she commences instruction because of the dangerous nature of their art, which not only can heal but also kill. Therefore, apprentices are carefully selected and rigorously tested to ensure their resistance to aggressiveness. Only if deemed non-aggressive and hence appropriate by an *ācāṇ*, a student is initiated into the lineage of the practitioner and receives the knowledge of *varmam*, both martial and medical. Then and only then do practitioners begin to teach their knowledge, which they usually work hard to conceal from outsiders. *Ācāṇs* are known to send bystanders away or to use blankets to cover their techniques from the eyes of the uninitiated when administering treatment—a most atypical behavior for South Asian patient-physician encounters (cf., Halliburton 2002: 1127).

Ācāṇs give priority to an experiential, hands-on learning approach opposed to a theoretical, text-based education. One practitioner cut me short after I had mentioned that I had read publications on *varmam*:

So, you've read in a book? I'll give you books! I bought a full rack of books: they're all "waste." They tell you that this is one spot and how to treat it: all wrong! Not a single *varmam* is true [*orē oru varmam uṇmaiṭillai*]. From books you cannot learn anything of value about the vital spots.

Whereas scholars have emphasized the important role of textual and, since recently, oral methods of instruction in South Asia (Subramanian 1986; Crook 1996), *ācāṇs* stress "experiential knowledge," *aṇupavarivu*, as the most effective form of education. It considers education as a process hands-on experience and experimentation which cannot be learned by reading or communicating. This is similar to what Obeyesekere calls "samyogic experimentation" (1993), noting that the clinical practice and medicinal preparation of ayurveda are constituted in experiments and experience.

In *varmam*, therefore, the sense of touch (*urraṛivu*) is of utmost importance. *Ācāṅs* have a common saying: “only a science which is learned through touching will become a science” (*toṭṭuk kāṭṭāta vittai vittaikkākātu*; Rājēntiraṅ 2008: 79; Irājēntiraṅ not dated). A commonly used Tamil word for teaching is *collikkoṭu-ttal*, literally “giving by saying.” Asked how he had been taught *varmam*, one practitioner denied having been taught verbally at all; rather, he said he had been taught *by giving*: *kāṭṭikoṭu-ttal*, literally “giving by showing.” An *ācāṅ*, when teaching massage techniques or how to set a fracture, guides the hands of a student, thereby non-verbally showing him the technique. The tactile and kinesthetic aspects of such therapeutic and martial actions are perfected through endless repetition. This, in part, explains for the long duration of learning.

The DVMS correspondence course

In marked contrast, an individual practitioner named Chidambarathanu Pillai has set up the “International Thanu Foundation” in Chennai, which offers various courses to study siddha medical subjects, and has coined the term “thanuology” as a label for *varmam*. Courses such as “Diploma in Siddha Medicine” (DSM), “Doctorate in Siddha Medical Sciences” (DSMS), and “Doctorate in Varma Medical Sciences” (DVMS) are taught in the English medium and all function as correspondence courses (Pillai 1995b: 4). These appear to be tailor-made to satisfy the needs of students outside Tamil Nadu and especially abroad, since study materials are in English and textbooks and exam questions are provided by mail and e-mail.

Pillai, born in Kanyakumari district in 1934, claims to be a hereditarily trained practitioner hailing from a family that has practiced as *ācāṅs* for 46 generations (Citamparatāṅupillai 1991: 76).⁸⁵ He “spent several years under

⁸⁵ Pillai thus claims to be able to trace back his ancestry over 1100 years

Gurukula system of study,” and has received degrees in Law, Commerce, and an M.A. in International Policy Studies. He has served in different, mostly government employments, ranging from Railways to the Madras Port Trust. With the expertise acquired in these working situations he has published a range of books on inventory management. Despite this entrepreneurial past, Pillai maintains that his entire life has been devoted to the study of siddha medicine. Thus, and “for the health care and welfare of the people abroad, [he] started dissemination of this sacred [*varmam*] knowledge in English in 1991” (Pillai 1996: 73). Pillai has authored over 60 books in Tamil on medical subjects since 1968. More than than 20 among these are devoted to *varmam*, a “valuable and antique medical art” (Pillai 1994: 5), still unknown to the world. He holds that *varmam* needs to be made known to the world not only because it is completely ignored outside of Tamil Nadu but also because vital spot injuries, according to him, are related to about 19% of all diseases. He estimates the same percentage of all ailments treatable utilizing *varmam* techniques. Pillai writes:

This system has been concealed for centuries, not allowing millions of people all over the world to come to know the techniques of Thanuology [*varmam*]. By long years of negligence of this precious art both by the people and the Govt. of Tamil Nadu in particular and the Govt. of India in general, this art is at the ebb of [a] disappearing stage (Pillai 1996: 3).

During his struggle against the supposed extinction of *varmam*, Pillai has conducted workshops on *varmam* impacts and treatment techniques, even abroad. After having held a speech on “Thanuology” at the 2nd Conference of the International Association for the Study of Traditional Asian Medicine (IASTAM) in Surabaya, Indonesia in 1984, Pillai has recently delivered a talk titled “*Varma Medical Science*” at the “World Classical Tamil Conference,” a conference for the promotion of Tamil language, history and arts with Tamil

(<http://www.varmam.com>, last consulted on 06.02.2013).

Nadu state support in June 2010 in Coimbatore.

According to an application brochure, applicants are only eligible for the “Doctorate in Varma Medical Sciences” (DVMS) course if they have either graduated from a recognized college or university or have obtained a diploma in medical science with two years of related work experience. However, I was assured in personal interviews that enrollment was possible at any time, even without medical experience or a degree.⁸⁶ It seems virtually everybody can enjoy the instructions offered. The course’s fees are 1,500 USD for foreign students and 26,500 INR (equivalent to 500 USD) for Indian Nationals. Although the application form for the DVMS course explains that “an average student devoting 12 hours a week” would complete the course in four-and-a-half years (DVMS Brochure-Cum-Application Form 2009), Pillai told me that a student may graduate faster. In one interview he lauded the efforts of some of his most outstanding students, including one Japanese student, who he said was so efficient in preparing for and passing the exams that he finished the DVMS course in less than nine months.

Pillai founded the “International Thanu Foundation” in 1989. In addition to educational facilities, this institution incorporates a dispensary for treating patients for *varmam* related ailments and a unit for producing medicines. The latter, called “Siddha Maguda Laboratories,” supplies medicines to graduates, even those living abroad. Pillai claims to have instructed as many as 500 students in siddha and *varmam* diploma courses and 200 in *varmam* doctorate courses at his institute. According to him, half are residents of India. The other half come from places such as the USA, UK, France, Belgium, Japan and Malaysia. Pillai has not yet achieved state accreditation for his institution or the degrees he offers, which he strives for despite his being in his late seventies. He is convinced that his institution will achieve recognition within the next few years. In attempting this, and in designing the DVMS courses, Pillai has worked

⁸⁶ Personal Interview with Chidambarathanu Pillai in Chennai on 27.03.2009.

to publicize and make *varmam* known and available to people around the world.

Publicizing and spreading varmam

Over the last few decades, Pillai has made several attempts to publicize the concept of the vital spots. The most pronounced of which are reflected in his marriage of Hindu religious icons and words and western science discourses, presumably to make *varmam* accessible to audiences both in India and around the globe, and notably to the effect of creating a distinct niche and brand for thanuology. For example, the front cover of the DVMS course brochure represents the image of god Śiva in a dancing posture with the subtitle “*medicina origini[s]*,” Latin for “medicine of the beginning.” Also reflective of this is Pillai’s renaming of *varmam* for his course as “thanuology,” and in his naming of the degree awarded to successful candidates as “ThD,” Diploma in thanuology, apparently emulating the “PhD” degree.⁸⁷ Pillai declares that *thanu* is a Name of Śiva, the god most revered by Hindus in Tamil South India. Pillai states that the therapies utilizing *varmam* are best identified by the god’s name since he is believed to have created the vital spots. Notably, Pillai’s first name, Chidambarathanu, contains *thanu* as well. Moreover, the term *thanuo-logy* makes *varmam* look *akin* to *physio-logy* and *neuro-logy*, by adding to *thanu* the English suffix *-(o)logy*, from ancient Greek *-logia*, literally meaning “account; explanation,” but which has come to enjoy the meaning of “science.” The coinage of thanuology might have been intended to familiarize the Euro-American scientific community with the vital spots by using a recognizable terminology, and thus exemplary of an often described influence of scientific, biomedical language in India (Alter 2005c: 12; Naraindas 2006).

⁸⁷ See <http://www.varmam.com/courses.php> (last consulted on 05.07.2012) and <http://www.siddhamedicine.com/thanufound.html> (last consulted on 05.07.2012). In earlier publications, Pillai uses the term “Varmology” (Pillai 1970).

On numerous occasions, Pillai has approached the Ministers of Health of both the Central Government and Tamil Nadu to recognize thanuology as a unique medical entity. As early as 1982 he unsuccessfully requested the establishment of a “National Institute of Varmam (Thanuology)” (Citamparatānupillai 1991: 48). During the 1980s and 1990s the Thanu Foundation approached Indian educational institutions directly, trying to urge the Universities of Madras, Poone and Mysore to consider introducing thanuology as a discipline in their academic curricula. After having been presented with a syllabus for thanuology, all institutions declined due to financial reasons (*ibid.* 1991: 58).

During the mid-1980s Pillai also tried marketing thanuology as a “Sports Medicine” to gain the International Olympic Committee’s recognition of it as a sports therapy. Pillai suggested that *varmam*, which he now labeled “Indian Sports Medicine (Thanuology),” ought to be funded by the IOC and utilized during Olympic sports events. The IOC asked Pillai to provide its members with a concise report on “Indian Sports Medicine,” which would then be evaluated by the Olympic Committee (1991: 55). After having assessed this report, an extensive work called “*Thanuology as Sports Medicine*,” the IOC wrote in a letter to Pillai that although its members were very impressed by the report and the practice of thanuology, “as a general rule the IOC Medical Commissioner or indeed the IOC [was] unwilling to promote any one particular type of sports medicine for use during the Olympic Games.”⁸⁸ Nevertheless, the IOC Medical Commission’s publication series, *IOC Medical Commission Collection of Sports Medicine and Sports Sciences*, a bibliography of Sports medicine, mentions Pillai’s report, which is kept in its library, archived as “Indian Sports Medical Science” (IOC 2006: 69).

⁸⁸ Letter by the Chairman, Medical Commission IOC, dated 31.10.1987. Cited in Citamparatānupillai (1991: 56).

Recently, the Thanu Foundation has begun to promote *varmam* as an emergency and accident medicine (Pillai 2008: 53). It has stated that thanuology is useful for treating ailments caused by injuries and physical impacts, which other medical systems, such as ayurveda, unani, homeopathy and biomedicine only partially understand or redress. In this light, Pillai claims that thanuology is an “emergency remedy,” and would furthermore be useful for forensic analyses and determining the cause of death (2009: 20).⁸⁹

Pillai, entrepreneur and promoter of *varmam* vital spots, attempts, more or less successfully, to publicize and spread *varmam* in different ways. A similar approach can be detected in the creation of a curriculum and in attempts to enroll students for the DVMS course.

Envisaging a student body, creating a curriculum

Rejected by both national academic institutions and international organizations, Pillai set up his own, private education facility in Chennai in the early 90s providing courses in siddha and *varmam*. Initially students came mostly from the city and its environs, and early text-books represented the vital spots against a mythological background, in which god Śiva and his divine family figure prominently. One text reads, for example, “The originator of Varmam (Thanuology) is Lord Thanu, the Creator. It was Lord Velmuruga [Śiva’s son] who mindfully imparted the secret aspects of striking life-centres to seer Agastiar” (Citamparatānupillai 1991: 70). This parallels the idea of siddha medicine’s creation expressed by most siddha practitioners and palm-leaf manuscripts. God Śiva is perceived as having created the knowledge of medicine and having passed it on to the Siddhars—semi-mythological saints, first and foremost amongst which is the mentioned Agastiyar. Thus, Siddhars

⁸⁹ <http://varmam.com/info/index.php/2006/11> (Last consulted on 05.07.2012).

can be seen as mediators between god and humans. Today, one of the textbooks used for the DVMS course reads:

Siddha philosophy goes above religion. It transcends all barriers of caste, colour, community, race, country, including objects – animate and inanimate. It is purely abstract and takes man to the ultimate goal of self-realisation, the very purpose of Birth as a human being (...) Siddha[r]s realised God within themselves (...) (Pillai 1994: 3).

Whether Pillai believes that such a notion is compatible with a creation myth, or whether it is the outcome of a deliberate shift of paradigms is difficult to assess. It is remarkable, though, that the “purely abstract” picture of siddha medicine, which “transcends all barriers,” is present in instruction materials for the thanuology distance course today. Pillai elsewhere writes that the “Siddha system of medicine has been developed purely by the contribution of Siddhars on their own line of thinking and achievements in the field of their research (...) on the basic principles of nature and its elements, after careful and thorough study of the human systems” (1996: 8). Such an argumentation reveals certain aspects of a perceived rational scientificity of siddha, expressed in ideas such as “research,” “careful and thorough study” and “based on scientific facts” (Pillai 1994: 11; compare Weiss 2009: 72).

Varmam practices as depicted from the DVMS material are not only based on a western model or on biomedical discourse, however. In addition to using western scientific nomenclature to describe and promote Siddha and *varmam*, the DVMS application brochure claims that thanuology’s strength lies in its rectification of biomedicine’s shortcomings. Biomedicine, through costly and risky surgical operations, created numerous medical problems which the vital spot methods could treat cost-effectively, non-invasively and safely (Pillai 2009: 3).

Pillai also distinguishes thanuology from other forms of non-western medicine. Acupuncture and acupressure, for example, have become increasingly popular around the world from the 1970s (Adams 2002: 251; Alter 2005b; Scheid 2006; Tang 2006) and have, in most of Europe and North America, gained unparalleled popularity as CAM, “Complementary and Alternative Medicine.” Today, acupuncture in particular is being utilized by many primary care practices and offered to broad sectors of the population (Tang 2006). This is important in our case because foreign DVMS students are often intrigued by a possible structural connection between acupressure, acupuncture and *varmam*, all of which share theoretical and practical approaches to therapeutic spots of the body. Being aware of acupuncture’s growing popularity, Pillai is keen to tell students that acupuncture and acupressure are “fundamentally different from Thanuology,” and that the management of the vital spots is effective in treating ailments which acupuncturists cannot address (Pillai 1994: 11). Interested practitioners of acupuncture, though, Pillai adds, would be gladly educated in the differences between them and on “the need for acupuncture to be complemented by Thanuology.”⁹⁰

As Laurent Pordié (2012) has shown in the case of the wellness industry, commercial success may depend on “branding,” that is, on differentiating therapies, services or locations through building of a unique identity. Similarly, the way the DVMS course is promoted carefully avoids coinciding with either a western or non-western medical practice. This might be Pillai’s attempt to create a distinct sphere of influence and importance for thanuology. With regard to prospective foreign students, who may not be Hindus except for Diaspora Indians, Pillai emphasizes a kind of rational secularity over Hindu mythology and at the same time delineates *varmam* from both biomedicine and

⁹⁰ Personal Interview with Chidambarathanu Pillai in Chennai on 27.03.2009.

other alternative treatment modalities.⁹¹ Somewhat unsurprisingly, therefore, Pillai notes in a recent publication that “Thanuology is an independent medical science” and even goes so far as to say that “[t]he view that Thanuology (Varmam) is a part of Siddha Medicine has been ruled out in as much as the techniques used in Varmam are quite different from other systems of medicine [but] unique of its own” (Pillai 1996: 4).

Translating the vital spots

Pillai admits to having designed the correspondence program to suit the needs of non-Indians. *Varmam* has become subject to translation in this endeavor. Much of the correspondence course materials required linguistic and terminological translations, such as the creation of the concept of thanuology. For instance, the therapeutic entities of the course, the vital spots, are called “life centres” or “nerve centres” throughout the instruction material (Pillai 1995b; 1995a; 1996). While most hereditary practitioners would agree on a *varmam* being a location of life (*uyir*), the case is more complicated with regard to “nerve centres” the term primarily used in DVMS textbooks. Since the material is in English, it never becomes clear whether “nerves” of these “nerve centres” correspond to *narampu* (nerves, in Tamil). This ambiguity is important to consider because *narampu* are recognized by hereditary practitioners as crucial aspects of *varmam*. Some vital spots, so I was told, are nerve-related, as these coincide with nerves, *narampu*. But not all *varmam* concur with nerves, others might relate to bones, *elumpu*. *Varmam* manuscripts divide the vital spots into those which are primarily composed of flesh (*māmicam*), vessels (*cīrā*), bones (*elumpu*), joints (*canti*) and nerves (Kaṇṇaṅ Rājārām 2007a; 2007b). Translating *varmam* into “nerve centres” creates a particular problem since it prioritizes nerves before other vital spots, intentionally or not, while other

⁹¹ Yet, interestingly, several studies on transnational Asian medicine stress that it is often their spiritual, religious characteristics of Asian medicines which appeals to both practitioners and patients in foreign contexts (Adams 2002; Janes 2002).

anatomical categories such as bones and joints are at least taxonomically underrepresented.

Prāṇa is a central concept in South Asian medicines. *Varmam* spots are generally perceived as permeated by it, as being “seats of *prāṇa*.” *Prāṇa* has been denoted as “vital breath,” or “air” in scholarly accounts (Rao 1987: 167). More recently, it has convincingly been argued that *prāṇa* transcends these concepts, denoting more closely “vital energy” (Zarrilli 1995), or “life” itself (*uyir*), as many *ācāṅs* put it. Integral to the functioning of the *varmam* loci, *prāṇa* resembles “electric currents” rather than breath, and, if stimulated, many vital spots trigger “current-like sensations”, as I was told by many patients after *varmam* manipulations in Kanyakumari district. Though always circulating through the body, *prāṇa* is concentrated at specific times at particular spots. These very places where *prāṇa* concentrates are *varmam* loci, which, when inflicted by physical impact, obstruct or block the flow of *prāṇa*. This obstruction has immediate consequences to a person’s health and, in severe cases, can lead to a quick death. In publications of the Thanu Foundation, *prāṇa* is labeled “oxygen” and it is described that “an impact at a nerve center obstructs the flow of oxygen and therefore life is at stake” (Pillai 1994: 12). Possibly to make the terms more accessible to people around the world, Pillai has translated concepts which figure in the practices and the textual sources of *varmam*, and some of these appear to have been replaced with his own understanding of biomedical concepts of anatomy and pathology. More examples of both linguistic and conceptual translations could be provided. However, I will analyze another case of translation at stake, one which is even more striking.

As described earlier, hereditary practitioners value practical and experiential learning more than textual knowledge. Even manuscripts dealing with *varmam* are said to be of no value if not complemented by the initiation of an accomplished *guru*; such manuscripts point out numerous aspects, such as the

stimulation of *varmam* spots, which can only be studied under the guidance of an experienced teacher. Yet, the same manuscripts are collected, edited, and translated into English and figure as important parts of the DVMS course's textbooks.⁹² The biggest leap of translation hence, I would argue, lies in the modes *varmam* knowledge and practices are transmitted. Consider a quote from a brochure for the correspondence course:

We have qualified and experienced tutors (...) who (..) examine students answer papers. They point out weaknesses and mistakes (...). We have many letters on our files showing how, as the course progresses there develops a strong bond of friendship between the tutor and the student, though they may never meet (International Thanu Foundation 2009).

Whereas hereditary knowledge transmission presupposes the student to live with his *guru*, the *tutors* of the DVMS correspondence course are "as near as [a student's] corner Post Box" (*ibid.* 2009). Students are expected to score at least 70% on each exam paper sent to them by either post or e-mail, which must be retaken if the student fails. The correspondence course has traded gurus for tutors; learning is done by reading and writing rather than by touching, the sense prized most by hereditary practitioners. Hence, one of the starkest translations made by Pillai in the forming of his course is his exchange of the senses, touch and kinesthesia for vision and mental reflection.

For hereditary practitioners, *varmam* consists equally of "healing" and "fighting," and the knowledge of one aspect supports and enables sufficiency in the other. However, due to the potential danger involved in *varmam* techniques capable of healing and killing, related knowledge is kept restricted by *ācāns*. They reveal their practices only to their students, who they select with the

⁹² For instance, Pillai (1995c) and (1995b) seem to be close translations of the manuscripts *Varma oṭimur̥iōu n̄ānam* and *Varma tiravukōl tirattu*.

utmost diligence and scrutiny. For hereditary practitioners morality and ethics play a crucial role in the instruction process. This does not appear to be the case for the DVMS course, as virtually anybody can enroll. An interest in the subject and a student's solvency, rather than trust and morality, are decisive factors which Pillai takes into consideration when selecting new students. Instead of being carefully selected, students of DVMS are enlisted by the conductors of the DVMS course. One of the most marked characteristics of the course is the way in which it transforms the siddha learning relationship from that of a moral economy into a market economy, a cash-and-carry commodity.

It is significant that, despite noted martial practices of many hereditary *ācāṅṅs* of Kanyakumari district, the course offered by Thanu Foundation is restricted to apparently therapeutically relevant aspects. The textbooks deal with *varmam* spots, relevant locations, ailments and treatment techniques. This excludes aspects of a combative applicability of the vital spots. Of course these would be difficult, if not impossible, to be integrated into books, or examined through exam questions. It is moreover interesting to acknowledge that in shifting the focus of attention in instructing *varmam* from the tactile, sensory capacity of students to discursive, mental and visual faculties, secrecy is being considerably de-emphasized. At the same time, it is precisely this shift from secrecy to openness that enables the translation from an instruction based on the physicality of life and the body to a physicality of texts and pictures in the first place. Nevertheless, if we bear in mind the non-verbalizable knowledge which most hereditary *ācāṅṅs* speak of, their emphasis on transmission via hands-on learning and mimesis, and the bodily nature of knowledge involved, we cannot but expect dramatic changes in both instruction and content of *varmam* through a medium such as the Internet, which is incompatible with the aforementioned aspects.

While the depicted modalities have only been briefly adumbrated here, they would deserve an in-depth analysis in order to understand contemporary ways of negotiating the theory and practice of *varmam*. Moreover, they allow for a reconsideration of processes of transfer and translation of knowledge.

Transnationalizing, transmitting, and translating varmam

The analysis of two modes of knowledge transmission reveals conflicting views on instruction, secrecy, theory and the practice of *varmam*. We see that aspects of *varmam* have been altered to fit the needs of the correspondence course. Such changes include the concealment of knowledge and the closed circles of knowledge transmission within lineages. They also include the experience-based, long-term instruction periods. Hereditary instruction requires the student to practice over a long period of time in order to train his or her body to *physically* learn the experience, thus attempting to meet the kinesthetic and tactile requirements of *varmam* practices. This is not part of the correspondence curriculum. In contrast, the correspondence curriculum is based on comparably short-term courses, which are conducted using the Internet as a space for transnationalization to bridge long distances between instructor and learner in the DVMS correspondence course. Rather than kinesthetically, students learn textually according to the correspondence curriculum. As a result, this evolving system of knowledge transmission factors out aspects which are of considerable importance to patients in South India: patients approach a particular physician for the medicine he or she administers. This includes issues of his or her popularity, age, lineage, social influence, reputation and moral conduct—issues which are often crucial for patients in deciding which practitioner to approach for which ailments.

Whereas hereditary practitioners carefully choose and accept their students, so as to conceal potentially dangerous and secret knowledge, virtually anybody

can enroll for the correspondence course. Secrecy exhibited by *ācāns*, can, at least partially, be explained by their strife to conceal the potentially lethal spots from misuse. This quality of secrecy is contested by Pillai, who insists that knowledge ought to be spread and saved for the benefit of humankind. What is more, and what makes a shift from concealment to publicity possible, is the fact that *varmam* medical practices are disconnected from martial practices that are part and parcel of a combined practice for many hereditary vital spot practitioners. Pillai's quest in the transnational instruction of *varmam* is thus one for transnational compatibility, or supra-cultural compatibility, in order to make *varmam* understood abroad. Amongst others, this is done by trying to constitute thanuology as *scientifically* effective and by de-emphasizing Hindu religious aspects at the same time, which helps to transform knowledge into a marketable commodity.⁹³

In contrast to the hereditary mode of *varmam* education, which largely places the aim and meaning of instruction on a personal, educational rapport, similar to the "humanist model of education" of Herman Nohl (1949)⁹⁴, we undeniably see a relationship of financial interests and of payment and supply of services in the case of the DVMS. This paper therefore argues that not only practices of medicine and medical substances must be seen as valuable market commodities, but also *knowledge*. Both Asian medicines and the transmission of their knowledge have become marketable commodities. thanuology in this regard can be compared to other innovations of traditional knowledge, especially in transnational contexts. Transnational commercial yoga, for instance, has been described by several scholars as a particular type of yoga which has arisen out of international commercial exchange (Alter 2004; De Michelis 2004; Fish 2006: 190). This means to acknowledge the market demand in North America, Europe, Japan and several other countries for indigenous

⁹³ On the relation between clinical research, Asian medicine and the making of commodities, see Pordié (2010: 62).

⁹⁴ See also Wulf (2003).

alternative healthcare practices. Thus thanuology can, at least in part, be seen as a transnational commercial interpretation of *varmam* therapeutic techniques and its value as a commodity. The example of commercial forms of yoga, a multibillion-dollar industry, in this regard may be of importance for triggering entrepreneurial transnational efforts. Such entrepreneurial forces, though, have hitherto not been satisfyingly explored with regard to siddha medicine, which scholars have described as largely influenced by Tamil nationalist agendas and development strategies (Weiss 2009; Hausman 1996). They have argued that siddha medicine in Tamil Nadu has increasingly become a cultural property, tantamount to “Tamil medicine” (Weiss 2009). To assert their legitimacy, practitioners demarcate themselves through their discourse from not only biomedicine but also, and especially, from ayurveda. Siddha medicine is closely related conceptually to current Tamil revivalist, nationalist strands within India. Therefore, while mainstream, state-level efforts appear to promote and develop siddha alongside a Tamil nationalist agenda, it is interesting to find within the siddha medical tradition individual, private efforts to go beyond this agenda.

Comparatively short-term courses are conducted using the Internet as a space for transnationalization to bridge long distances between instructor and learner in the DVMS correspondence course, which utilizes material in text form. This space, a virtual classroom in our case, is similar to the academic world: it is highly ocularcentrist and logocentrist—prioritizing the vision and the logic of the word or text. The case at hand affirms Regina Bendix, who notes that “logocentrism, generated in conjunction with ocularcentrism has contributed to a certain amount of neglect of culturally shaped sensory knowledge” (2005: 7). Linda Harasim has described online education as a “new environment, with new attributes and [which] requires new approaches to understand, design and implement [instruction]” (1990: 7). This new environment is the “virtual classroom,” a space—the cyberspace, to be

precise – which requires adaptations and new approaches to teaching a subject matter. This is not just the case with regard to *varmam*, although the adaptations may be all the more apparent here. Studies on on-line education have pointed out various transformations happening in the processes of instruction, the different forms of teaching available through the Internet, for instance, or the new possibilities of virtual textbooks (Rossman 1992). I would furthermore like to suggest that such changing forms of education transform their subjects. The case of *varmam* distance education exemplifies how an instruction medium may influence how the message, or content, is perceived, and how the Internet shapes the kind of knowledge that can be transmitted. This happens, for example, by selecting from the corpus and by thus transforming it, but also by translating a particular concept so that it may be transmittable, receivable and understood globally, via a medium such as the Internet. Thus, instead of inquiring into the re-appropriation of knowledge in a different scenario, I argue for a need to enquire into the re-appropriation of medical knowledge as communicated, that is, to understand ways in which education and instruction are shaped. In this respect, Marshall McLuhan's well-known dictum, "the medium is the message" (1973), holds true.

Conclusion

A major ground and cause of translation of South Asian healthcare can be found in the transport of medical practices across borders, or rather, the transmission of knowledge underlying these practices. The modes of transnational transmissions described here appear to bring about modifications in the way siddha medicine is perceived, and presumably in the way it is practiced. It is the interests of the persons, groups or institutions of instruction, based on alleged perceptions and expectations of potential foreign recipients of the course, which shape the subject of instruction. Such perceptions therefore influence the way siddha is transmitted and communicated. Previous studies

on transnationalization of medicine have largely focused on practices and their flows. Regarding healthcare, transnationalism thus has been understood as the promotion and spread of medicines and medical practices beyond the national borders of a conceived area, where a particular medicine is found to be at home—a notion, in itself highly awkward and delicate, as it regards nation-states and a particular medicine as congruent (Alter 2005a). The case presented here however shows that knowledge itself becomes transmuted and it is argued that this happens not only in the course of this transfer, but as a *necessity for the transfer of knowledge*. In the case of *varmam*, a long-term instruction by apprenticeship and through esoteric, secretive lineages seems hardly practicable in a transnational scenario, and therefore the instruction offered by Thanu Foundation appears as one alternative, feasible option.

While initially transnational studies have focused on processes of transformations of commodities and practices of European and North American origins being transported and adapted elsewhere, in this, a “unidirectional bias” (Howell 1995) was soon detected and a considerable amount of studies on non-European or North American commodities and practices were identified, which flow to the aforementioned, being likewise transformed in the new setting. It has been argued that whereas the general trend in transnational discourses emphasizes a hegemony of North American and European culture and thought (the “West”) (Fardon 1995; Høg and Hsu 2002: 206), a number of case studies, especially of transnationalized Asian medicine helps to countervail such an argument. Glocalizations of Asian Medicine, it is stressed, are examples of a spread of technology transfer and knowledge and practice streams not from the West to the East, but vice-versa, from the East to the West. Of primary attention are religious, spiritual and medical practices in this regard. This is also underscored by many of the findings of this paper. But the assumption underlying the aforementioned publications is largely that (re-)adjustments of commodities and practices are being conducted within new settings and “upon

transfer” (Adams 2002: 248; Høg and Hsu 2002: 212). Indirectly, these works argue that diversification and re-contextualization happens in the recipient culture alone. There are notable exceptions, some of which point to conscious decisions of re-defining traditions when Asian, and other, medical practitioners are writing or performing for western audiences and in order to satisfy the desires, or again the sensory experiences of foreign clients and to be exported globally (Pordié 2011; 2012; White 2006). As Asian medicines are introduced into new settings, they are transformed and re-contextualized not merely in the new localities. The case of *varmam* shows that such re-contextualizations occur according to modes of instruction, possibilities and economical market considerations, and through the transmission of knowledge itself. This includes gaps of cultural understanding and translations, and, what is more, the appropriation under the influence of a particularly transnationalist type of learning: the Internet. This, also, is a reason why the outcome practices of the DVMS course and the medical techniques utilized by a holder of the said degree in the USA, Japan, or Germany are moot in this paper, as it is assumed that this is not the sole, but rather another, second ground of translation.

Reconstructions of *varmam* are occurring simultaneously in individual attempts by self-styled *gurus*, teachers, and instructors, in the modes and forms of instruction available to those, in expectations and ongoing correspondence with students and in discourses and notions of medicine and science. These are important sites for the study of transnational healthcare and its transmission.

This paper therefore demands the recognition of not only patient agency, practitioner agency or institutional agency as crucial factors in the processes of the globalization of Asian medicines but also of the agency of the instructor/teacher/*guru* on the one side and of students, the recipients of knowledge, on the other. The teacher-student relationship appears as especially important in this regard as it is able to control a potential commodification of

medicine and to “produce a synthetic discourse of theoretical innovation”
(Alter 2005b: 26).

References

- Adams, Glyn 2002: Shiatsu in Britain and Japan: Personhood, Holism and Embodied Aesthetics, in: *Anthropology & Medicine* 9 (3), 245-265.
- Alter, Joseph S. 2004: *Yoga in modern India: the body between science and philosophy*, Princeton: Princeton University Press.
- Alter, Joseph S. (ed.) 2005a: *Asian Medicine and Globalization*, Philadelphia: University of Pennsylvania Press.
- Alter, Joseph S. 2005b: Ayurvedic Acupuncture–Transnational Nationalism: Ambivalence about the Origin and Authenticity of Medical Knowledge, in: Alter, Joseph S. (ed.): *Asian Medicine and Globalization*, Philadelphia: University of Pennsylvania Press, 21-44.
- Alter, Joseph S. 2005c: Introduction: The Politics of Culture and Medicine, in: Alter, Joseph S. (ed.): *Asian Medicine and Globalization*, Philadelphia: University of Philadelphia Press, 1-20.
- Bendix, Regina 2005: Introduction: Ear to Ear, Nose to Nose, Skin to Skin–The Senses in Comparative Ethnographic Perspective, in: *Etnofoor* 18 (1), 3-14.
- Castells, Manuel 1996: *The Rise of the Network Society*, Cambridge: Blackwell.
- Citamparatānupillai, S. 1991: *Taṭṭuvarmat tiraṭṭu: Striking Nerve Centres in Varmam*, Ceṇṇai: International Institute of Thanuology.
- Crook, Nigel 1996: *The Transmission of Knowledge in South Asia: Essays on Education, Religion, History, and Politics*, Delhi: Oxford University Press.
- Daniel, E. Valentine 1984: The Pulse as an Icon in Siddha Medicine, in: *Contributions to Asian Studies* 18, 115-126.
- De Michelis, Elizabeth 2004: *A History of Modern Yoga: Patañjali and Western Esotericism*, London: Continuum.
- Dolby, Nadine/Cornbleth, Catherine 2001: Introduction: Social Identities in Transnational Times, in: *Discourse: Studies in the Cultural Politics of Education* 22 (3), 293-296.

- Fardon, Richard 1995: *Counterworks: Managing the Diversity of Knowledge*, London: Routledge.
- Fish, Allison 2006: The Commodification and Exchange of Knowledge in the Case of Transnational Commercial Yoga, in: *International Journal of Cultural Property* 13, 189-206.
- Halliburton, Murphy 2002: Rethinking Anthropological Studies of the Body: Manas and Bodham in Kerala, in: *American Anthropologist* 104 (4), 1123-1134.
- Harasim, Linda M. 1990: *Online Education: Perspectives on a New Environment*, New York: Praeger.
- Hausman, Gary J. 1996: *Siddhars, Alchemy, and the Abyss of Tradition: "Traditional" Tamil Medical Knowledge in "Modern Practice"*, PhD Thesis, Michigan: University of Michigan.
- Held, David (ed.) 1999: *Global Transformations: Politics, Economics and Culture*, Cambridge: Polity Press.
- Høg, Erling/Elisabeth Hsu 2002: Introduction, in: *Anthropology & Medicine* 9 (3), 205-221.
- Howell, Signe 1995: Whose Knowledge and Power? A new Perspective on Cultural Diffusion, in Fardon, Richard (ed.): *Counterworks: Managing the Diversity of Knowledge*, London: Routledge.
- International Olympic Committee 2006: *IOC Medical Commission: Collection of Sports Medicine and Sports Sciences*, Lausanne: International Olympic Committee.
- International Thanu Foundation 2009: *Doctorate in Varma Medical Sciences: Brochure-Cum-Application Form*, Madras: Thanu Foundation.
- Irājēntiraṇ, T. not dated: *Caracūkśattiravukōl – 36*, Maṇali: Kastūri piras.
- Janes, Craig R. 2002: Buddhism, Science, and Market: The Globalisation of Tibetan Medicine, in: *Anthropology & Medicine* 9 (3), 267-289.
- Kaṇṇaṇ Rājārām, T. 2007a: *Varma maruttuvam (ciraṇṇu) Varma Medicine (Special)*, Muñciṇai: A.T.S.V.S. Citta Maruttuvakkallūri.

- Kaṇṇaṇ Rājārām, T. 2007b: *Varma maruttuvattiṇ aṭippaṭaika!* (Fundamentals of Varma Medicine), Muṇḍirai: A.T.S.V.S. Citta Maruttuvakkallūri.
- Krishnamurthy, K.H. 1984: Siddha System of Medicine: A Historical Appraisal, in: *Indian Journal of History of Science* 19 (1), 43-53.
- Mariyajōcap, A. not dated: *Varmakkaṇṇāṭi - 500: mūlamum uraiyum*, Maṇalikkurai: Muttu nūlakam.
- McLuhan, Marshall 1973: *Understanding Media: The Extensions of Man*, London: Abacus.
- Naraindas, Harish 2006: Of spineless babies and folic acid: Evidence and efficacy in biomedicine and ayurvedic medicine, in: *Social Science & Medicine* 62 (11), 2658-2669.
- Nohl, Herman 1949: *Pädagogik aus dreißig Jahren*, Frankfurt am Main: Schulte-Bulmke.
- Obeyesekere, Gananath 1992: Science, Experimentation, and Clinical Practice in Ayurveda, in: Leslie, Charles/ Allan Young (eds.): *Paths to Asian Medical Knowledge*, Berkeley and Los Angeles: University of California Press, 160-176.
- Pillai, Chidambarathanu S. 1970: *Varma kaimuṇṇai ētu* (Handbook of varmology), Madras: International Institute of Thanuology.
- Pillai, Chidambarathanu S. 1994: *Philosophy of Thanuology (varma kuravanji)*, Madras: International Institute of Thanuology.
- Pillai, Chidambarathanu S. 1995a: *Intellection in Thanuology*, Madras: International Institute of Thanuology.
- Pillai, Chidambarathanu S. 1995b: *Retrieval Techniques in Thanuology*, Madras: International Institute of Thanuology.
- Pillai, Chidambarathanu S. 1995c: *Wisdom on Dislocations, Breakages and Damages in Thanuology*, Madras: International Institute of Thanuology.
- Pillai, Chidambarathanu S. 1996: *Pulse Reading in Thanuology (varma naadi)*, Madras: International Institute of Thanuology.
- Pillai, Chidambarathanu S. 2008: *Siddha System of Life* 32 (4).

- Pillai, Chidambarathanu S. 2009: *Siddha System of Life* 1 (1).
- Pordié, Laurent 2010: The politics of therapeutic evaluation in Asian medicine, in: *Economic & Political Weekly* 45 (18), 57-64.
- Pordié Laurent 2011: Accentuations et pragmatisme: Le savoir médical tibétain à destination des étrangers, in: *Revue d'anthropologie des connaissances*, 5 (1), 99-130.
- Pordié, Laurent 2012: "Branding Indian Aromatherapy. Differentiation through transnational networks", in: Scheid, Volker/Hugh MacPherson (eds.): *Integrating East Asian Medicine into Contemporary Healthcare*, London: Elsevier/Churchill Livingstone, 199-213.
- Pordié, Laurent/Jean-Paul Gaudillière in press: The Reformulation Regime in Drug Discovery: Revisiting Polyherbals and Property Rights in the Ayurvedic Industry, in: *East Asian Science, Technology and Society*.
- Rājēntiraṅ, Ār. 2008: *Varmakkalai: putumaiyāna tarkāppu muraikaḷ*, Cennai: Capariś pāraṭi.
- Rao, S.K. Ramachandra 1987: *Encyclopedia of Indian Medicine: Vol.2, Basic concepts*, Bangalore: Parameshvara Charitable Trust.
- Robertson, Roland 1995: Glocalization: Time-space and Homogeneity-heterogeneity, in: Featherstone, Mike/Scott Lash/Roland Robertson (eds.): *Global Modernities*, London: Sage.
- Rossmann, Parker 1992: *The Emerging Worldwide Electronic University: Information Age Global Higher Education*, Westport/London: Greenwood Press.
- Scheid, Volker 2006: Chinese Medicine and the Problem of Tradition, in: *Asian Medicine* 2 (1), 59-71.
- Sébastien, Brigitte 2010: Governmental Institutions vs. Associations: The multifaceted expression of Siddha Medicine in Tamil Nadu. <http://halshs.archives-ouvertes.fr/halshs-00408677/fr/>.

- Sébastien, Brigitte 2010: Le Passage des Frontières de Médecines pas très Douces: Prévenir l'innocuité ou Préserver l'authenticité? Le Problème des Formulations Iatrochimiques dans la Médication Siddha, in: *Revue d'anthropologie des Connaissances* 5 (1), 71-98.
- Selby, Martha Ann 2005: Sanskrit Gynecologies in Postmodernity: The Commoditization of Indian Medicine in Alternative Medical and New Age Discourses on Women's Health, in: Alter, Joseph S. (ed.): *Asian Medicine and Globalization*, Pennsylvania: University of Pennsylvania Press, 120-131.
- Subramanian, S.V. 1986: *Heritage of the Tamils: Education and Vocation*, Madras: International Institute of Tamil Studies.
- Sujatha, V. 2009: The Patient as a Knower: Principle and Practice in Siddha Medicine, in: *Economic & Political Weekly* 44 (16), 76-83.
- Tang, Suzanne 2006: "From Outcast to Inboard": The Transmission, Professionalisation and Integration of Acupuncture into British Medical Culture, in: *Asian Medicine* 2 (2), 254-276.
- Weiss, Richard S. 2003: *The Reformulation of a Holy Science: Siddha Medicine and Tradition in South India*, PhD Thesis, Ann Arbor: University of Michigan.
- Weiss, Richard S. 2009: *Recipes for Immortality: Medicine, Religion, and Community in South India*, New York: Oxford University Press.
- White, David Gordon 2006: *Kiss of the Yoginī: "Tantric Sex" in its South Asian Contexts*, Chicago: University of Chicago Press.
- Wulf, Christoph 2003: *Educational Science: Hermeneutics, Empirical Research, Critical Theory*, Münster: Waxmann.
- Zarrilli, Phillip B. 1995: Traditional Kerala Massage Therapies, in: *Journal of Asian Martial Arts* 4 (1), 67-78.
- Zarrilli, Phillip B. 1998: *When The Body Becomes All Eyes: Paradigms, Discourses and Practices of Power in Kalarippayattu, a South Indian Martial Art*, New Delhi: Oxford University Press.

Zimmermann, Francis 1992: Gentle Purge: The Flower Power of Ayurveda, in:
Leslie, Charles/Allan Young (eds.): *Paths to Asian Medical Knowledge*,
Berkeley: University of California Press, 209-223.

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