THAILAND'S BARE-HEADED DOCTORS
หมอพระในประเทศไทย

David Gosling
เดวิด กอสลิง

Faculty of Theology, University of Hull
คณะศาสนศาสตร์ มหาวิทยาลัยฮัล

ABSTRACT

Thailand, with its resilient Buddhist culture, such communities are best created and maintained by Buddhist monks, whose unbroken historical continuity provides them with an ideal opportunity for transforming Thai society from within. While many of the principles set out in what follows may be valid outside Thailand and among non-Buddhist Thai minorities (Catholics, Protestants and Muslims), there appears to be a uniqueness about the potential role of the Thai Sangha *as a vehicle of social change. For the last few years an imaginative programme for training Buddhist monks in basic health care has been in operation in Thailand. The scheme, originally based on two* wats *(temples) in Bangkok, is now being extended to the Northeast where poverty and malnutrition are most acute. This article is based on fieldwork conducted in Thailand in 1983. It evaluates the programme from the point of view of participant monks, setting it against the background of traditional and modern medical practice.*

บทคัดย่อ

ประเทศไทยมีวัฒนธรรมที่สำคัญยิ่งคือพุทธศาสนา ประชาชนชาวไทยให้ความเคารพนับถือพระสงฆ์ มีความศรัทธาว่าเป็นผู้ที่สร้างสรรค์และดำรงรักษาสิ่งที่ดีงามให้แก่สังคมไทยตลอดมา แม้ว่าภายในสังคมไทยจะมีการเปลี่ยนแปลงจากอดีตถึงปัจจุบันค่อนข้างมาก สถาบันสงฆ์ก็ยังคงมีบทบาทสำคัญในการควบคุมการเปลี่ยนแปลงให้เป็นไปอย่างถูกต้องเหมาะสม

ในระยะ 2–3 ปีที่ผ่านมามีผู้จัดทำโครงการหมอพระขึ้น เพื่ออบรมพระสงฆ์ให้มีความรู้ทางด้านการรักษาสุขภาพอนามัย โดยเริ่มอบรมที่วัดสามพระยาและวัดเบญจมบพิตรก่อน ต่อมาจึงขยายการอบรม

ไปยังวัดในภาคตะวันออกเฉียงเหนือ การอบรมเน้นการใช้สมุนไพรรักษาโรคแทนการรักษาแบบโบราณและแบบสมัยใหม่ซึ่งปรากฏว่าได้ผลดีและไม่สิ้นเปลืองค่าใช้จ่าย

INTRODUCTION

Dr. Prawase Wasi, the originator of the Thailand's bare-headed doctor programme traces its genesis to a three-week course in health care which he directed at *Wat Thongnopakun* in *Changwat* Thonburi in 1976. More recently *Wat Samphraya* and *Wat Benjamabopitr* in Bangkok have been offering five-day courses for groups of up to fifty monks recruited from Central and Northern Thailand. By January 1984 plans were afoot for less centralized schemes based on regional centres in the Northeast.

The research was conducted in August 1983 by interviewing a dozen monks who had taken part in *Maw Phra* (Doctor-Monk) training schemes based on *Wat Samphraya* and *Wat Benjamabopitr* in Bangkok. The monks were interviewed at their home *wats* in order to ascertain what practical difference the course had made to them. Invariable they mentioned the ability to diagnose accurately, the importance of prevention rather than cure, and the use of a combination of indigenous herbal and inexpensive modern medicines.

Besides, approximately 350 young scholar monks at Mahachulalongkorn Buddhist University were requested to answer the detailed questionnaires about their attitudes towards the role of the *Maw Phra* in the context of Thai rural life and Buddhist beliefs and practices. The questionnaire was designed in the light of the earlier interviews thus anthropology shaped sociology.[4] The data was analysed on the University of Hull's ICL-1904-S computer.

The focus of the investigation was the monks' own understanding of the potential role of the *Maw Phra* in relation to both contemporary social needs in rural Thailand and how "appropriate" or otherwise certain activities are from the point of view of Buddhist orthodoxy. It is not possible, for example, to understand why a monk who is willing to give an injection to a man may none-the-less feel it totally inappropriate to do the same for a woman, without recognizing the importance of the *Vinaya* (rules of conduct which are binding on members of the *Sangha).*

The *Maw Phra* programme is important not only on account of its culturally sensitive fusion of tradition and modernity, but also because of its potential as a means of creating long-term self-reliance among communities hitherto undermined by rural-urban and ultimately international patterns of dependency. While national and international legislation to curb the activities of

the drug multinationals may be important, the only long-term solution is to create vigorous self-reliant indigenous communities which are no longer obliged to satisfy their medical and other basic needs within a context of dependency.

Rural Health Care

The "medical geography" of rural Thailand is a complex mix of government health care and traditional practice. The former is divided into four levels of which the first three are Government financed and the fourth, though Government sponsored, is voluntary. Tertiary medical care is highly specialised and based on large hospital. Dr. Prawase Wasi, who originated the *Maw Phra* programme, was Director of Siriraj Hospital and Vice-Rector of Mahidol University, both of which are located in Bangkok Metropolis (*Krung Thep Maha Nakhon*).

Secondary medical care is based on provincial (*Changwat*) hospitals of which there are 73 provinces in the country. At the district (*Amphoe*) level less than half the total of 661 districts possessed hospitals a few years ago, and of these only 80 had more than 30 beds.[8] Primary health care tends to be based on *Tambol* (village administrative unit) rather than *Amphoe*; a typical *Amphoe* with a population of 50,000 may be made up of 18 *Tambol*, each of which may contain 12 *Moo-Baan* (hamlets). The basic components of primary health care are nutrition, health education, water, immunisation, basic treatment, essential medicines, maternal and child health and sanitation. Voluntary health care occurs at *Tambol* and *Moo-Baan* level.

A typical *Amphoe* hospital may be staffed by three doctors, five nurses, three midwives (*Phadungkhan*), a sanitarian and a dentist. There may be two or three health clinics under its jurisdiction (plus that of the *Amphoe* health officers), each run by a sanitarian and a midwife. Sanitarians and midwives train for approximately a year at *Changwat* hospital schools. It is important to distinguish government midwives from traditional village midwives (*Maw Tamjee*). The former fulfil a much broader role than the delivery of babies, and can also function as "injection doctors" (*Maw Chiid Jaa*).[7] Much more could be said about the various levels of official health care. But it is at the village (*Tambol* and *Moo-Baan*) level that the modern and traditional medical systems intermesh and at which the *Maw Phra* is able to fulfil an important role The most frequently encountered traditional practitioner was the *Maw Boraan*, whose range of functions both complements and overlaps those of government personnel at the *Tambol* clinic (except that babies are always delivered by the midwife). Mr. Panpikul is a famous *Maw Boraan* for curing children's illnesses at Bang Pa In. He is also known as *Maw Suk* (*Suksala*), which suggests that he holds an official medical position. His use of herbal medicines (*Samun Prai*) is one of the most characteristic features of a *Maw Boraan* and is central to the *Maw Phra* programme. Such indigenously prepared medicines not only cost much less than their imported counterparts, but often produce fewer side effects. Mr. Panpikul's medicine chest included cummin oil and *Borapet* * (*Tinospora tuberculata* Beumee), the stem is used to treat fever.[9]

* The Thai names of medicinal plants were obtained from the practitioners and were checked by botanists from Mahidol and Chulalongkorn Universities.

The role of *Maw Saiyasat* (magic doctor) seemed to be diminishing. Only one *Saiyasat* monk was encountered in the Northeast; a lay *Saiyasat* practitioner interviewed in Doi Saket (*Changwat* Chiang Mai) had learned his arts as a novice at the nearby *wat*. *Saiyasat* activities were seldom mentioned in the Northeast, and there is evidence that their role in village life is diminishing. Jane Bunnag reports that "in *Changwat* Phra Nakhon Si Ayutthaya at least, very few monks were *Saiyasat*."[1] Phra Khru Sakorn Sangvorakij, the influential abbot of *Wat Yokkrabut* in *Changwat* Samut Sakhon and a close associate of Dr. Prawase Wasi, maintained that local villagers dislike *Saiyasat* practitioners. It is important to note that in any given locality they tend to be recognized for particular skills. Howard Kaufman reports from Bangkuad on the activities of two *Maw Boraans*, one of whom is also a head teacher, plus a woman Shaman: "Each specializes in one aspect of healing and they do not actually compete with each other."[6]

Village headmen (*Puyaiban*) and schoolteachers (*Khru*) may function in either traditional or modern medical sectors. It would not be particularly unusual in the Northeast to find a headman who is both a government health volunteer and a *Maw Khwan* (the lay officient at *Khwan* rites).

General characteristics of the respondents

Mahachulalongkorn University is one of Thailand's two monk universities, began in 1890 when King Chulalongkorn moved the monastic school at the Chapel of the Emerald Buddha to *Wat Mahathat*. It was accorded university status in 1947. In any given year between 350 and 450 monks may be enrolled for the four year B.A. degree. Mahachulalongkorn caters for Maha Nikai monks whereas Mahamakut based on the prestigious *Wat Bovornives*, is Dhammayut. Education at both is free, funds being derived from the government, the *Sangha* and private sources. Monks attend classes in the afternoon and early evening.

Mahachulalongkorn describes its main aim as being to provide monks and novices with a level of education commensurate with the tasks of understanding and preaching the *Dhamma* in contemporary situations. The curriculum is designed "to present the fundamental Buddhist principles and doctrines in terms understandable to modern man and in the manner applicable to modern living, both individual and social." The first two years of the B.A. are spent in the Faculty of Buddhism after which candidates can either remain in the same faculty or opt for Education or Humanities and Social Welfare. All students are expected to meditate regularly and to participate in development programmes. These latter involve practical activities such as the construction of roads, bridges, wells, water pumps, sanitary facilities, power lines, schools and *wats*, and it is against the background of these programmes that the *Maw Phra* scheme should be set. William Klausner has described the involvement of the *Sangha* in such activities in the Northeast of Thailand.[5]

Practical development programmes raise major questions as to the "appropriateness" of certain actions for monks. According to the 227 precepts of the *Pātimokkha* a monk must not dig the earth or damage plants. This rules out the chopping down of trees, but doesn't mean that a monk can't saw a log if somebody else has felled the tree (or it has fallen). It is not "appropriate" for a monk to propel himself in a vehicle because insects and small creatures may die, but he may paddle a canoe, and nowadays may ride on a bus.

The *Pātimokkha* is particularly important in Thailand because the reforms of King Mongkut, from which the Dhammayut order (or "sect" - neither word is particularly satisfactory) originated, were largely based on it. But the notion of "appropriateness" also contains a significant psychological dimension derived from the values and mores of Thai society. Exceptions to certain activities appear to be made when it is clear that they carry forward the basic purposes or principles of Buddhism. Thus the success of Phra Chamrun, the abbot of *Wat Tham Krabok* near *Changwat* Saraburi, in curing heroin addiction, is generally held to justify such traditionally inappropriate activities as clearing up lay peoples' vomit, building and operation sauna baths, and administering a large community of volatile young men and women.

It will be clear from what has been said that medical activities on the part of a monk need careful evaluation before they can be regarded as appropriate. Virtually all monks at the Buddhist universities have migrated to the capital from the provinces, especially the Northeast. It is important to distinguish in general terms between monks who ordain at an early age in order to secure a good education and those who ordain for a short time often for specific reasons such as the bestowal of merit (*Bun*). Typically a boy may have completed compulsory primary education by the age of thirteen, obtaining the highest grade (Prathom seven). He could then ordain to the noviciate at a *wat* near his home and pursue traditional *Pariyattitham* studies based on Pali language and texts. To take the higher *Pali Parian* examinations he would probable have to move to a provincial capital where he might ordain as a monk in his early twenties, moving eventually to Bangkok where he might enrol for the B.A. at Mahachulalongkorn or Mahamakut. This, however, is something of an oversimplified picture, and there is a wide spread of possible options. Monks increasingly choose secular educational routes because these equip them for a broader range of jobs if and when they disrobe.[2,3] By the time they reach the Buddhist universities they may be in their late twenties or thirties. It is not appropriate, incidentally, for a monk to study at a secular university because this would bring him into an unacceptable level of contact with women.

The first six questions in the questionnaire cover the monks' biographies, qualifications and educational routes. Three hundred and forty of the 400 who received questionnaires returned them. Of these 41% came from the Northeast and 19%, 18% and 19% were born in the North, Central and Southern Thailand respectively. Two respondents came from the Metropolis and six from outside Thailand, notably Indonesia and Nepal. The questionnaires, incidentally, were distributed and collected during class periods by Phra Maha Narong Cittasobhano, the much respected Dean of the university.

Eighteen per cent of the sample (25 monks) were born in *Changwat* Nakhon Ratchasima, which is not surprising since it contains the largest population in the Northeast. *Changwat* Khon Kaen, with 11% of the sample from a population two-thirds of the size, is equally predictable. But *Changwat* Surin (12%), *Changwat* Si Sa Ket (10%), and *Changwat* Roi Et (9%) are unexpected in comparison with *Changwat* Udon Thani, which has a larger population than *Changwat* Khon Kaen (or at any rate had in 1976), and yet accounted for only 1.4% of the sample. *Changwat* Ubon Ratchathani, with 4.3% of the sample coming from a comparatively very large population, is probably a typical in that its population decreased between 1970 and 1976 as shown in Table 1.

The *Maw Phra* in village context

Respondents were asked to specify who, in their home villages, performs specific functions. Seventy-one per cent stated that most babies were delivered by the traditional midwife, 16% specified the government midwife, 11% gave the *Amphoe* hospital, and 2% a local health volunteer. Clearly traditional midwives are very much in demand in spite of the fact that their government equivalents also perform other roles such as giving medicines and injections.

Forty-nine per cent of the sample said that the sanitarian gave most injections, 17% specified the *Amphoe* hospital, 12% mentioned unofficial doctor, and 11% each specified a private clinic or the government midwife. Seventy-eight per cent combined with both western medicine and medicinal herbs. Twenty per cent indicated western medicine alone, and 2% specified *Samun Prai.* It was clear that the monks understand the legitimate role of modern medical science.

Table 2 indicates the first choice of medical assistance for specific health problems in the monks' home villages. The unofficial doctors, who in practice give a sizeable proportion of injections (12%), are ranked consistently low. The *Maw Saiyasat* only comes into his own with psychological problems (28%), and, surprisingly, severe stomach pains (15%). The *Maw Boraan* scores higher on severe stomach pains (39%), which is not very satisfactory because severe stomach pains indicates the possibility of appendicitis. Perhaps he, like the health clinic, is consulted only for preliminary advice. Fever, which is unlikely to be particularly serious initially, is handled effectively by the health clinic (41%), but malaria is much more appropriately dealt with at the *Amphoe* hospital (39% as compared with 12% for fever). A rabid dog bite should be directed to either the clinic (42%) or hospital (36%) for the necessary injections, though some respondents thought that the *Maw Boraan* could be of assistance.

So far the category monk has scored quite low for the various ailments (9-15%). But for psychological problems he comes into his own (40%). Similarly an *Amphoe* hospital, presumably with specialists on hand, is better equipped than a health clinic (32% as compared with 12%), though the *Maw Saiyasat* does surprisingly well (28%). This must be on account

of the belief that spirits are responsible for mental ill health. But the presumed role of the monk as the person to whom one should go first with psychological problems is interesting and important.

Table 3 shows a series of possible functions for a *Maw Phra.* In each case respondents were asked to state whether or not, in their personal opinion, a particular role is appropriate. Eighty-seven per cent of the 340 respondents endorsed the view that the curing of psychological illness is a legitimate role for a *Maw Phra.* This is not surprising in view of what has already been noted. But it is interesting that the curing of fever (89%), teaching of sanitation (98%), and giving of herbal medicines (88%) rank even higher. Many monks teach sanitation during their regular sermons and grow their own *Samun Prai* in *wat* compounds. Diabetes is presumably stabilised rather than cured (81%), and stomach pains are likely to be treated with *Samun Prai* (80%). But the difference between the appropriateness of giving an injection to a layman (75%) and to a woman (15%) is enormous, and clearly reflects the structures of the *Pātimokkha* (which is part of the more comprehensive *Vinaya).*

Sixty-six per cent of the respondents thought it is appropriate for a monk to use a stethoscope and test blood pressure. Sixty-two per cent approved of the teaching of family planning, and 56% thought that a monk should try to cure sickness by *Samathi* (a less specific term for meditation than *Vipassanā*). The fact that 30% of the sample thought that it is appropriate for a member of the *Sangha* to attempt to cure venereal diseases reflects the frankness and pragmatism of Thai monks in dealing with what elsewhere are often regarded as "moral" issues. Twenty-eight per cent of the sample believed that a monk could exorcise a bad Winyān, 24% thought that he could cast a spell to remove sickness (which amounts do much the same thing), 15% approved of giving an injection to a woman, and 5% thought that it is appropriate for a monk to deliver babies. This last is not only inappropriate on account of the degree of contact with a woman presupposed, but it is unnecessary because it is the legitimate role of both kinds of village midwife.

CONCLUSION

The *Maw Phra* scheme has an enormous potential for preventing and alleviating rural health problems, and doing so in a manner which circumvents the misuse of expensive imported medicines since the monks are taught to administer an admixture of cheap modern drugs and indigenous *Samun Prai.* From the point of view of historical Buddhism the *Maw Phra* represents not so much an adaptation as the rediscovery of an ancient role (thereby giving the *Sangha* a stronger sense of identity both in the eyes of its members and the general public).

It is important to recognize that the effectiveness of the *Maw Phra* is due to the fact that it interprets the concerns of the past and of the present in such a culturally potent manner,

and that no amount of external funding, training and effort could ever hope to achieve the same. In a country which has not been subjected to western colonial domination and perhaps in some which have the indigenous culture is the only true context for significant social change. Religion (*Sasanā*), in harmony with the other two overarching Thai institutions, the Nation and the Monarchy, is the primary vehicle for social transformation.

In the long run there is only one solution to the stultifying dependencies which drain the lifeblood from rural and poor urban populations everywhere, and this is the creation of self-reliant communities which utilize a combination of traditional and modern expertise, the main criterion for which being its appropriateness in a given situation as determined by the people themselves. And in Thailand the Buddhist monks are playing a crucial role in bringing such communities into being.

ACKNOWLEDGEMENTS

The author wishes to express his gratitude to the National Research Council of Thailand for permission to carry out this research and to the British Academy for a grant to fund it. Also to his research advisors, Dr. Prawase Wasi and Phra Maha Narong Cittasobhano, for their constant advice and encouragement. He also received assistance from Dr. Sulak Sivaraksa, Dr. W.J. Klausner, Dr. Surakiat Achananuparp, Mrs. Netnapa Kumtong, and, of course, from the 340 scholar monks at Mahachulalongkorn University who so conscientiously completed his questionnaire.

REFERENCES

1. Bunnag, J. Buddhist Monk, Buddhist Layman. Cambridge University Press, London, 1973, 22, 59,74,149.
2. Gosling, D. New Directions in Thai Buddhism. *Mod. Asian Studies*, 1980, **14** (3), 411.
3. Gosling, D. Redefining the Sangha's Role in Northern Thailand : An Investigation of Monastic Careers at Five Chiang Mai Wats. *J. Siam Soc.*, 1983, **71** (1-2), 75.
4. Jacobs, M. The Alliance of Anthropological and Sociological Concepts and Methodologies in Field Research in Thailand. *J. Siam Soc.*, 1974, **62** (1), 35.
5. Klausner, J.W. Reflections in a Log Pond. Suksit Siam, Bangkok, 1972.
6. Kaufman, K.H. Bangkhuad : A Community Study in Thailand. Monographs of the Association for Asian Studies no. 10, Charles E. Tuttle, 1976, 35.
7. Riley, N.J. and Santhat, S. The Variegated Thai Medical System as a Context for Birth Control Services. Working paper no. 6, Mahidol University, 1974.
8. Wasi, P. Health Services and Medical Education in Thailand. Research Report, Mahidol University, 1978.

Table 1. Province of origin of Northeastern respondents at Mahachulalongkorn University

Province (*Changwat*)	Proportion of sample %	Population of province (1976) thousands
Nakhon Ratchasima	17.9	1778
Surin	12.1	940
Khon Kaen	11.4	1239
Si Sa Ket	10.0	1002
Roi Et	9.3	1007
Buri Ram	7.9	1025
Nakhon Phanom	7.1	703
Maha Sarakham	5.7	713
Kalasin	4.3	707
Ubon Ratchathani	4.3	1428
Nong Khai	2.9	576
Sakon Nakhon	2.9	724
Loei	1.4	404
Udon Thani	1.4	1331
Chaiyaphum	0.7	786

Table 2. First choice of medical assistance for specific ailments

	Severe stomach pains %	Fever %	Malaria %	Rabid dog bite %	Psychological problems %
Monk	15	12	10	9.4	40
Health clinic	40	41	42	42	12
Amphoe hospital	19	12	39	36	32
Maw Boraan	39	29	18	25	14
Unofficial doctor	3.8	4.1	5.3	1.5	1.2
Maw Saiyasat	15	9.1	8.2	6.8	28

Table 3. The monk's estimation of appropriate roles for the *Maw Phra*

Function of *Maw Phra*	Whether appropriate (%)
Teach sanitation	98
Cure a fever	89
Give *Samun Prai*	88
Treat psychological illness	87
Cure diabetes	81
Cure stomach pains	80
Give an injection to a layman	75
Use stethoscope and test blood pressure	66
Teach family planning	62
Cure sickness through meditation	56
Cure venereal diseases	30
Remove a bad *Winyān*	28
Cast a spell to remove sickness	24
Give an injection to a woman	15
Deliver babies	5