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Discursive Practice of Thai Traditional Medicine in Hospital: Case Study of a District Hospital in Nakhon Pathom Province

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The purpose of this research was to study the discursive practices to explain the contestation of knowledge about Thai traditional medicine (TTM) in the context of a district hospital in Thailand. This study applied the ideology of Foucault (1980). Data was collected using observation and validated by in-depth interviews with TTM practitioners, medical doctors, pharmacists, nurses and patients. Content analysis was used for analyzing the data. The result indicated that the discursive practice of TTM in hospital was based on knowledge. The positive aspects of TTM were holistic health care, health promotion, natural and safe, and cost effective. The negative aspects involved lack of choice in using alternative medicine, old-fashioned, low-awareness and less knowledge, and the perception of the "mhor nuad" (massager/masseur) as unprofessional. The resistant behaviors of TTM in the hospital were challenged by developing self-subjectivity through maintaining identity, public relations, integrated knowledge, intervened knowledge, denial in action, and refusal to service. Biomedicine was believed to apply scientific knowledge and an arrangement of working patterns of TTM service. This played a pivotal role in managing and controlling the position of TTM; also viewed as unequal since it gave a medical doctor the power to control and to limit the TTM service. The provision of TTM in hospital should be fully integrated and should be more than only a choice or an alternative. This could help develop health care services and a better management of knowledge between traditional and modern medicine for providing sustainable and holistic health care in hospital.

Keywords: Thai traditional medicine, biomedicine, discourse, discursive practice

Traditional medicine has grown to be of interest in both health care and popular sectors (Lewith, Kenyon, & Lewis, 1996). With regard to popular sector, people with chronic illness utilize not only mainstream medicine for their health, but also alternative forms of medical treatment such as traditional medicine and other kinds to manage their health problems such as cancer, heart disease, AIDS, stress, and others (Putipun, Nongnuj, & Panjachat, 2012).

In European countries, 10-25% of the adult population reported using one or another form of alternative health care during the year while it was estimated that 40% of the adult population used traditional medicine in the United States (Cooper & Stoflet, 1996). Eisenberg et al. (1998) studied the trends of traditional medicine used in the United States between 1990 and 1997 and found that the use of at least 1 of 16 alternative therapies during the previous year increased from 33.8% in 1990 to 42.1% in 1997 and the probability of users visiting a traditional medicine practitioner increased from 36.3% in 1990 to 46.3% in 1997. He extrapolated that 47.3% of the United States population would increase in total visits to traditional medicine practitioners, from 427 million in 1990 to 629 million in 1997. Besides, the National Center for Complementary and Alternative Medicine (National Center for Complementary and Alternative Medicine, 2008) and the National Center for Health Statistics of United States released findings on Americans' use of alternative medicine in 2007 and found that approximately 38% of adults and approximately 12% of children are using traditional medicine.

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In Thailand, biomedicine has come into the mainstream healthcare system, and Thai traditional medicine (TTM) has become a branch of nonconventional or alternative medicine. Eventually, it was well recognized that biomedicine was probably not the answer to the good health of Thai people since a large amount of the country's healthcare expense was spent on the treatment of diseases with high-priced sophisticated equipment and imported new drugs more than on the prevention of diseases and health promotion. In addition, despite all the advancement of medical technologies and the pharmaceutical industry, they cannot successfully cure several chronic lifestyle-related diseases, which are major health problems of today's world, e.g. diabetes, hypertension, cardiovascular diseases, and various types of cancer. In order for Thailand's healthcare system to become more self-reliant and cost-effective, Thai government then looked back at the country's heritage of wisdom of health care and acknowledged the role of TTM and herbal medicines that can play on the health of Thai people for the treatment of common minor diseases, disease prevention and health promotion. The revival of the TTM began around 1978 (World Health Organization [WHO], 2005). Thailand's Ministry of Public Health responded to the WHO's call by including such policy to promote the use of herb in the primary health care since the 4th Health Development Plan. The government policy on the promotion of the use of Thai traditional herbal and TTM in the health care system has continued until today as stated in 5th to 10th National Economic and Social Development Plans. The increasing popularity of using TTM is prominent among Thai people. Using TTM in Thailand has prospered with the change of health problems according to a more complicated society and economy. A number of studies consistently found that many of patients increasingly utilized TTM. The study by Putipun et al. (2012) found that 60.9% of Thai chronic patients, such as cancer patients, used traditional medicine as an alternative medicine. About 51% of the chronic patients reported positive effects from using it. The majority 58.3% of patients did not disclose their use of traditional medicine to their doctors because 65.9% of patients felt that it was not necessary for doctors to know. And, in the study of Wiwanitkit (2003) found that 95% of Thai chronic patients, such as HIV-infected patients, used traditional medicine and 78% visited traditional medicine providers. Besides, a recent study revealed that 53% of Thai population used herb and 43% of Thai population used massage to promote their health and heal their health problems (Sherer, 2008).

In health care sector, the TTM is a part of hospital health care in Thailand. It is prevalent that both public and private hospitals including private clinic operate the TTM (Chungsathiansap & Tantipidok, 2007). There are 92 hospitals or 95.83% of provincial public hospitals and general hospitals providing TTM, 677 hospitals or 93.25% of district community hospitals providing TTM, 8,990 or 91.91% of community health centers providing TTM and 86% of Thai private hospitals customarily use the TTM such as massage, spa, aromatherapy, herb, and other kinds of TTM (Srijaroenjira, 2003). However, the traditional knowledge was influenced by the receptivity of modern medicine (Salgureo, 2007).

For the situation of traditional medicine in hospitals, Srijaroenjira (2003) studied the status of traditional medicine provided in hospitals and found that 60.0% of the hospitals provided only some types of traditional medicine such as TTM, massage, and natural therapy. He also found that hospital executives had an influence on the growth of TTM in hospital health care and some of biomedicine practitioners still did not trust or need traditional medicine treatment. These affect the situation of TTM in hospital. Although TTM is provided in hospital, it is a subordinate system in hospital because the ideology of TTM is distinctly

different from biomedicine. Biomedicine depends on scientific method, but TTM does not emphasize it (Chungsathiansap & Tantipidok, 2007). Although the knowledge base of each area is different in nature, it is embedded within the bureaucratic hospital system that divides the healthcare system into sub-units of operation (Mychel, 2009). The functioning in the hospital is fractured by the conflict between the bureaucratic system existing within the organization by medical doctors who are in a powerful position to reject any attempt to control the practice of all medical practitioners (Amandy & Stephen, 2004). When hospital provides TTM, under the biomedical system, alternative medicine must follow biomedicine paradigm. To do so, everyone practicing TTM should be required to undergo an examination. The government needs to make the licensing in medical system uniform (Naoki, 2007). It means that TTM would be subjected to scientific testing. Biomedical practitioners who refer patients to traditional medicine generally believe that it is an appropriate alternative if there is a good reason to believe that it could do no harm. The scientific ideology of quality standards of biomedicine that emphasizes the scientific evidence base, objectivity, and experimental data would influence on the emerging of TTM under the structural context and condition of biomedical science. In the study by Shuval, Mizrachi, and Smetannikov (2002), it was found that while small numbers of traditional medicine practitioners were practicing in a wide variety of hospital departments and in a board of specialties, they were in no way accepted as regular staff. According to Daniel's study (2006), patterns of professional interaction among traditional medicine and biomedicine practitioners in integrative health care settings have been found. He found the patterns of power relation between biomedicine and traditional medicine including the pattern of patient dominating by referrals and diagnostic tests and decision by biomedical doctor, regulating traditional medicine practitioners to a specific sphere and accepting only proven data, and using biomedical language as the primary mode of communication.

It is clear that there is an imbalance power in the medical relationship. Medical professions have the upper hand because of the status given to their knowledge and professional standing, and their position in the class structure as highly educated (Foucault, 1980). The study by Amandy and Stephen (2004) found that within the global theme medical relationships, the challenged relationship between doctors and hospitals has the largest impact on the provision of service. The relationship to some extent was a symbiotic of power and controls which doctor was held over hospital control and the dominance and emerged power has a major impact upon hospital function.

Biomedicine has influenced and affected the field of TTM provision in the hospital. According to Michel Foucault, modern medicine plays a pivotal role in managing and controlling all health problems in hospital field and power is a relationship that patient has become dependent on the professional doctor (Foucault, 1973). The form of power exercises through discourse and discursive practice by knowledge. Medicine knowledge and technologies employ power to determine the condition and practice by scientific techniques including body examination and using equipment with modern technologies. When TTM is provided in hospital, medical doctor also makes a decision and an influence to the delivery and position of TTM. And when doctors use traditional medicine or order to combine the two types of medicine, doctors necessarily need to improve the quality (Naoki, 2007). If some kind of traditional medicine is found to be reasonably safe and effective, it will be accepted (Wisutwet, 2007). The situation of TTM is influenced by the attitudes of medical professions including the prognosis with standard treatments and potential harmful side effects. Biomedicine is believed to be the best medical system applying practical medically scientific knowledge and technologies and arrangement of working patterns in service organization

(Foucault, 1973). Hospitals have transformed to be symbolic for biomedicine too. The structure of biomedicine becomes the main ideology that influences the health system, especially in hospitals. Hospital could be viewed as core institutions of biomedicine. The scientific method includes medical discourse dominated all ideology of medical systems in hospitals. Only science was accepted as a modern material of validity and based upon the scientific information for biomedicine. In biomedical model, only doctors know what is important to individual's health because of their knowledge and profession (Gibson, 2004). The doctors maintained their professional autonomy and remained the main decision makers in hospital.

Although the government gives priority to TTM, it is not suggested that the TTM is fully integrated. Much of previous research on traditional medicine emphasized on the reasons of traditional medicine uses or provisions, the types of using, perception on the effectiveness, and frequency of using. There are very few studies on the discursive practice of traditional medicine in the hospital. The concept of Michel Foucault focused upon questions of how some discourses have shaped and created meaning systems that had gained the status and currency of truth, and domination. Knowledge and power always interconnect. Every embodiment of knowledge involves an increase in power. However, the nature of discourse is the set of the corresponding combined with the lack of unity and stability. It comes together in a variety of different discourses. Each set of discourse is a strategy to come together in different forms (Foucault, 1980). We had a chance to study in order to understand the system or rules of discourse from the presence of discourse directly by only study the opportunities and terms of discourse that allow us to communicate and be understood from the discursive field of the discursive practice which can be done through the study and the search process of the subjectivity which is meaningful to the TTM in the hospital context. Discursive practice of a discourse can be expressed through the statements, whether it is a verbal, text, symbols, and series of the conservative ideas, beliefs, values, and practices that are associated as well. The discursive practice constructs subjectivity of TTM which involves the opinion, belief, and values to practice. This will provide the new knowledge and indicate the contestation of knowledge of TTM in hospital.

Research objective and Questions

The research objective was to study the discursive practice to explain contestation of knowledge of TTM in a hospital context. The concentration of this research is to seek response to the questions:

1. What is the discursive practice of TTM in the hospital?
2. How is the contestation of knowledge of TTM?
3. How is the resistance of TTM in the hospital?

Methods

Study Site

This research used the ethnography approach in qualitative research methodology because it considered the participants as one of "us" and participants feel free to talk to the researcher as a friend or as a person at the same level. The power relation between the participants as the research subjects and "I" as the researcher was equal. This insider position helps me get into very personal and sensitive experiences of participants. The purposive selection is the

methodology used for selecting TTM provisioned in district hospital to be the informant. The sampling hospital selection was one governmental district hospital in Nakhon Pathom Province in Thailand. Researcher selected the sampling hospital as an appropriate informant because it has had TTM services provided for more than 10 years until now and has developed under the management of medical doctors. The sampling hospital is a small size governmental hospital of about 60 beds. The informant hospital is the best practice hospital in TTM service.

Informants and Participants

To answer the questions, data collection consisted of recruiting 13 key informants Six participants are under 40 years old, four are 41-50 years old, and three are over 50 years old (9 females and 4 males). The in-depth interviews and observation can be divided into three groups as follows:

1. Biomedicine practitioners including: 2 medical doctors (1 female and 1 male), 2 nurses (females), and 1 pharmacist (male) who have worked in the hospital for at least 5 years.
2. TTM practitioners including: 2 applied TTM practitioners (1 female and 1 male), 1 TTM practitioner (female), and 3 massage staff (females) who have at least 5 years of work experience.

3. Three patients (2 females and 1 male) who have used TTM for more than 6 months.

The area of ethics in human research of this study demonstrates an understanding of the "Protection of Human Research Subjects" ethics of the Mahidol University's Institutional Review Board.

Data Collection

The study collected data from May 2011 to April 2012 by using methodological triangulation including the interviews, observations, and cross-checking data from multiple sources to search for regularities in the data. In-depth interviews lasted about 45-60 minutes each with the key informants and analyze context of hospital, discourse and its discursive practice that pertaining to TTM in hospital, contestation and resistant of TTM in hospital. To analyze, not only the in-depth interview but also observations were applied. Observations were carried out from the field to determine the TTM provisions in hospital, and to observe the context of the hospital by emphasize the space and position of services and management structure.

Qualitative data analysis was applied in this study. The data was analyzed by using content analysis and depended on data from in-depth interviews and observations, on the topic of the research objectives by application of the ideology and concepts of Michel Foucault as power depended on discourses and discursive practice which provided knowledge and practice through discourses.

Results

Description of TTM services

TTM in the hospital was provided in the department of rehabilitation and TTM. The structure of the department was controlled by the head who was a nurse. There were 2 practitioners of applied TTM and 1 qualified public health official who were trained in TTM from Ministry of Public Health and about 22 massage staff in the department. TTM service was controlled by medical doctor who was the hospital director through the head of department who was a nurse. In the past, TTM practitioner was called "TTM doctor" or "mhor/phat phan Thai" but now it was changed by the Ministry of Public Health's policy to be "(applied) TTM practitioner" or "phat phan Thai pra yuk" that was one form of discursive practice of power through the identified language to control the position of TTM by reducing it from traditional doctor to one of supporting professionals.

There were many patients using TTM services in the hospital. There were 18,527 patients and 19,844 patients using TTM in the hospital in 2008 and 2009 respectively. There were 19,436 patients (about 39.79% of population) using TTM in hospital in 2010. The hospital received 5,819,446 Baht income from TTM services fee in 2010. The numbers of 87.74% of TTM patients in 2010 were caused by musculoskeletal diseases such as muscle strain, myalgia, osteoarthritis of the knee (OA-knee), back pain, and 12.26% of TTM patients in 2010 were caused by others such as tension headache, peptic ulcer (PU), high-density lipoprotein (HL), upper respiratory tract infection (URI), and cerebrovascular accident (CVA) as shown in figure 1.

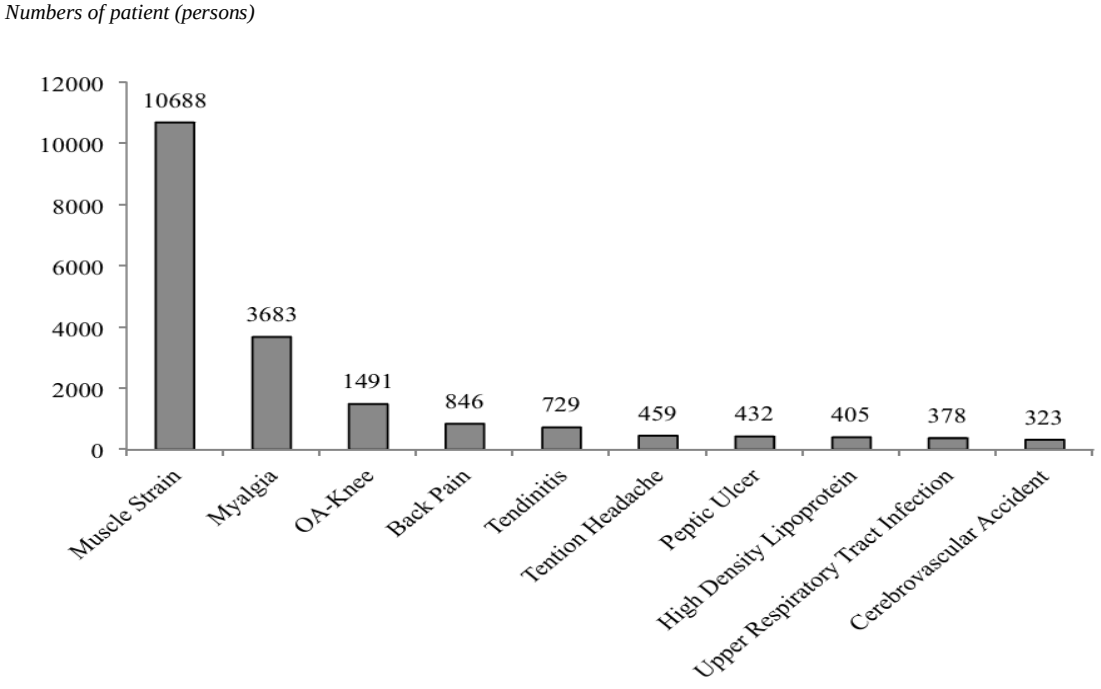

Figure 1. The patients of Thai traditional medicine department

There are 7 types of treatment services that patients used in the hospital. They are Thai massage, body massage, face massage, foot massage, herbal ball massage, herbal medicine, post-partum or puerperium care (*thap mor kear* or Thai clay pot with salt), and sauna. Sometimes patients used more than one type. For example, patient might use body massage and foot massage, use herbal ball massage and herbal medicine, etc., which could be summarized as shown in figure 2.

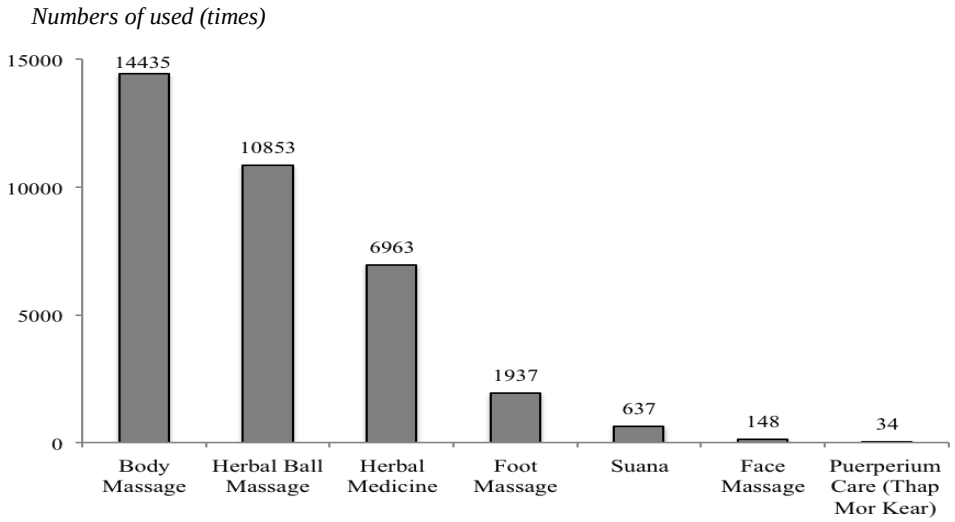

Figure 2. Types of TTM used

Discursive practice of TTM in hospital

The discursive practice of TTM in hospital was based on knowledge and made use of knowledge. The concept of the discursive practice of TTM was the relationship between knowledge, biomedicine institutions, subjectivity and power. Discursive practice of TTM in hospital could be classified into positive aspects and negative aspects series. The positive aspects of discursive practice played a huge role constructing reality as metapower in the form of a set of knowledge about the positive side of TTM involving holistic health care, health promotion, natural and safety, healer, and cost reduction. The holistic health care was the main concept of TTM. It influenced the reasoning of the provision of TTM in the hospital. The holistic health care was the idea that the professionals needed to emphasize spiritually, mentally, and physically. It constructed knowledge and subjectivity that influenced the opinion, belief and meaningful values. And, patient viewed TTM that it could help promote their holistic health not only body care but also mind and emotion therapies. And, the discursive practice of health promotion of TTM was on the threshold of exciting developments in health and health care of the hospital. Health promotion was a pivotal point of an expanding public health movement. The professionals believed that TTM could help the hospital to develop health promotion for their patients. Patients would use TTM such as herbal medicine and massage for relaxing and promoting their health. They believed it could help them live longer than using modern medicine. An example statement is as follows:

"I would use TTM if I wanted to relax and have health promotion. My family and my friend suggested I use it for promoting health. It could help live longer than chemical drug used." (Patient L, female – 28 years old)

The discursive practice of the naturalistic and safety of TTM produced meaning of health that emphasized on safety and naturalistic care. These were based on traditional practice that was considered to be natural therapy treatments. Biomedicine practitioners believed in the naturalistic of some types of TTM that had evidence to support the safety and efficiency. Patients viewed TTM as a natural treatment and natural product that was safe and did not create side effect. The used of TTM in hospital would request a proved or test for safety and effectiveness. Some types of TTM had found their place into the medical practice standard in the hospital. So, much knowledge of TTM was lost and disappeared in the hospital.

The power of TTM was constructed from the acceptance and need of patient. TTM constructed itself as equal to patients whom it was helping. There was also a language shift from patients to customer that really showed the differences between how biomedical and TTM practitioners view people under their care. Biomedicine deals with people as patients while TTM called them customers rather than patients. This explains their attempt to empower the patients. TTM practitioners were divided to the healers. Massage staff might perceive the term healer when taking the position of healing somebody. But they wanted patient to work together with their massage staff by patient's decision. TTM constructed itself as equal to those whom it was helping. An example statement is as follows:

"I could express my opinion about one of my treatment. TTM practitioner would suggest if something could not be used. And, I could express my need if I thought that some herbal medicines could be used for my health. If I went to biomedical doctor, I could not do this. I thought it was because I had less knowledge about the modern medicine. The name of modern medicine or drug was in English. And, a (biomedical) doctor always made me feel dependent." (Patient L, female – 28 years old)

Besides, the discursive practice of TTM through integrative approaches achieved through lower utilization of expensive medical interventions such as pharmaceutical and medical visits and the fact that many of these interventions reduces hospital expense.

The negative aspects of the discursive practice of TTM involved choice and alternative, old-fashioned, Ayurveda and non-scientific, low-education and less of knowledge, and the representative of mhor nuad and unprofessional constructed the lower position of TTM in the hospital. The discursive practice of choice and alternative of TTM influenced the subordination position of TTM which reduced its true value. This discursive practice occurred not only in the hospital but also in the government policies. The provision of TTM in hospital was related to the rationalities and government's policies to increase choices and it could be an alternative treatment to decrease side effects for patient. An example statement is as follows:

"The word alternative made TTM look like only a choice and an alternative. TTM had less power in this concept. Biomedicine didn't fully accept it because we were only an alternative." (TTM practitioner A, female – 27 years old)

TTM was subjected to traditional knowledge that was old-fashioned. The professional concepts toward TTM seem to claim to legitimize features of biomedical knowledge that it was still to be seen as modern. Modernizing it involved practitioners and organizations and standards to follow, governing and practices. In this discursive practice, it led to the moving between standard images of a health care professional and an innovative vision of what TTM professional could be. Biomedical doctor did not understand the traditional language of TTM and some medical doctor did not believe in the knowledge of traditional medicine that was

old-fashioned medicine, out of date, and should be developed in the same way as biomedicine.

In addition, the discursive practice of Ayurveda and non-scientific has allowed mainstream biomedicine to gain a monopoly. TTM was also viewed as unbelievable and non-scientific practice. In the view of medical doctor, the concept of TTM was related to knowledge. It was influenced by the discursive practice of low-education and less of knowledge of TTM. Biomedicine strived for a standard of care that was based upon the scientific information. An example statement is as follows:

"We have known that medical doctor also had higher knowledge. Biomedicine is more accepted than TTM. If we emphasized on the role between TTM and biomedicine, surely, it would be unequal. The reason was the scientific education level." (Patient M, female – 35 years old)

Besides, TTM was referred to as mhor nuad (massager/masseur) and the meaning of that is viewed as "unprofessional". Although TTM was provided in the hospital, patient viewed Thai traditional massage staff as mhor nuad. It was also unprofessional in the meaning. Someone looked down on massage staff. The history of massage therapy has been marginalized as associated with unprofessional. It has seen to have the sexual connotations of the word mhor nuad or masseur that it had come to exist in an action of disrespectful behaviors. Patients viewed TTM's massage staff as mhor nuad who was unprofessional. Social constructed the meaning of TTM and reduced it from the whole traditional treatment to only massage type of mhor nuad which is not important. Someone looked down on massage staff and did not understand its true value. The discursive practice of mhor nuad and the belief of being unimportant had increased boundaries between professional and nonprofessional. Besides that, the influence from the massage ideology in prostitute business since 19th century in Thailand has constructed mhor nuad as a sexual job. That caused some massage staff molested by their patients because they were dealing with sexual parts of body. However, the constructed belief of nonprofessional of their status had influenced the view of biomedicine to have had less quality. An example statement is as follows:

"Customers called me mhor nuad. They would not understand us. If my head did not stop me, I would hit many customers. For them, mhor nuad was like a prostitute." (Massage staff J, female – 56 years old)

Massage staff wanted to take pride in being health care practitioners. They tried to replace the unprofessional and sexual image with the show of massage as the type of healing by using techniques of professionalism to develop professional status for their practice.

Contestation of Knowledge

The contestation of knowledge of TTM in the hospital was its limitation too. The hospital was a space of experience of form that contested the application of norms that regulated. The hospital provided TTM including Thai massage, body massage, face massage, foot massage, herbal ball massage, herbal medicine, and others. The integration between TTM and biomedical services was interesting. Trend of the growth of TTM was the result of the positive aspects of the discursive practice of Thai traditional medicine. The hospital wanted to develop the health care services of the hospital. The way of organized practices of TTM was related to rationalities and techniques of economic and financial. The hospital would gain profit from herbal medicine products and massage services and the efficiency of these. When

TTM was provided in the hospital, it would provide the service standard for the hospital. An example statement is as follows:

"The integration between biomedicine and TTM could be used together by concentrating on decreasing cost and hospital could gain money from TTM services." (Nurse G, female – 36 years old)

Although the government gives priority to TTM, it is not suggested that the TTM is fully integrated. The idea of using TTM in hospital would need to rapidly develop the capacity of traditional knowledge that was a scientific and technical support of biomedicine to explain. TTM provided in hospital was not the pure traditional knowledge but it was applied science. TTM practitioner must be licensed before working in the hospital or providing services to patients. The role of TTM was limited in treatment of diseases. It was the result of the negative aspects of the discursive practice of Thai traditional medicine. There was a systematic rejection of other perspectives and an insistence that biomedicine was the chief force that had led to the huge improvements in public health. TTM services were selected by scientific methodology and concept of reason which depended on biomedical knowledge. It was also used for therapy such as relaxation, pain relief, and health promotion. The difference in scientific knowledge made traditional knowledge is that it is not approved in the hospital. An example statement is as follow:

"TTM services had not covered the treatment of disease, just for promotion or for prevention. Many types of TTM had less of scientific knowledge so it was limited." (Medical Doctor E, female – 41 years old)

In the hospital field, biomedicine was believed to be the best medical system that applied scientific knowledge and arrangement of working patterns in service. It played a pivotal role in managing and controlling the position of TTM. That was the form of power relation. Since biomedicine identity was dominant, it had shaped the terms of massage therapy for constructing TTM department's identity. The scientific knowledge had an influence on the acceptance of some types of TTM and some herbal medicine products which had research supporting the efficiency and safety. The boundaries of biomedicine and their licensor established what TTM practitioners and staffs were and were not allowed to do or said as professionals. It meant that, if TTM practitioners wanted to be professional, they must do what biomedicine did.

TTM had lower power than biomedicine. Biomedicine's scientific knowledge was accepted as a higher education and had influenced the position of TTM in the hospital. For example, the position's name of TTM practitioner was only a practitioner not a doctor. This made the meaning of having lower ability than medical doctor. So, they had lower acceptance to make a decision. A problem with integration was seen to be. Biomedical doctors tried to take over and control TTM. TTM department has used the same system with biomedicine such as information system, documentary system, treatment process system, and technology. There was a use of scientific knowledge to discipline a service. Medical doctor tried to manage the process of TTM's practice in the hospital the same way as biomedicine. Besides that, all modalities of TTM were communicated in language of biomedicine. TTM in hospital had tried to change to the same way as a unity to biomedicine system and using biomedical language as the primary mode of communication. An example statement is as follows:

"Some of TTM knowledge I had studied was lost because I could not use it. Some words could not be used in the hospital, such as pid-ta (fire) and wa-ta (water), and others." (TTM practitioner A, female – 27 years old)

In the hospital, biomedical knowledge is more accepted than TTM knowledge. Different knowledge influences different power. TTM practitioners had a lower role in the treatment decision. When TTM is provided in the hospital, medical doctor also makes decision and influences the delivery of TTM. If some kind of TTM, such as massage, was found to be reasonably safe and effective, it would be accepted. This is the result of scientific method to discipline all ideology in the hospitals. Only science is admitted as a modern material of validity and based upon the best available scientific information. It is clear that there is an imbalance power. The hospital is a central organization form where medical doctors are a major deliver in medical services. In the hospital, biomedical is accepted as the best way of health system. Medical doctors have control and use medical knowledge to manage the practices of TTM. An example statement is as follows:

"Some medical doctors and nurses did not accept TTM. Sometimes they had both intended and not intended to look down on TTM. They often asked about scientific research supported. Someone thought that TTM should not be provided." (TTM practitioner A, female – 27 years old)

In addition, biomedicine plays a pivotal role in management and decision making of all health problems in hospital field which depends on professional doctor. TTM practitioner has a lower decision making power than medicine doctor because they do not have enough knowledge in biomedicine point of view. The decision power has been shifted to doctor's hands many times. Medical doctor has a decision-making power and influence to a lower position of TTM in hospital.

Besides, the sexual connotation attached to massage therapy and it has posed problems for massage staff. The massage environment in the healing space is warm and may use beds and lotions that is a specific essential oil that can motivate a sexual environment as opposed to a healing environment. An example statement is as follow:

"I had faced the problem of hand molestation. Many male customers used their hand to touch my body, my hip, and my hand. They did not respect my job. I did not even have to do anything because I must do my duty completely." (Massage staff I, female – 42 years old)

It was clear that massage staff had pointed out the relationship between them and their patients that represents the contestation of disrespect and molestation. The lower status of the massage staff is due to their work evolving from economic reasons.

Resistance of TTM in the hospital

The resistance of TTM was challenging in terms of a creative traversing of the field of possible action. The actions of TTM were concerned with capacities of development and effectiveness in service. Although TTM was provided in biomedical field, it still maintained its traditional identities in the hospital that included belief and praying and also sacrifice. TTM also had its identity in the hospital such as worship shelf of Jivaka Kumar Bhacca's graven image, the father of TTM doctor, and the image of Buddha in the department. It was the form of belief and non-science in the hospital. It was one form of the resistance to the scientific paradigm. An example statement is as follow:

"Dr. Jivaka Kumar Bhaccha was a distinguished medical doctor during the Lord Buddha time. He was being honored as the father of TTM and herbal therapy, massage, and many more. He became thus the Teacher. We have his image's shelf for praying and remembering our identity." (TTM practitioner C, female – 49 years old)

The other identity of a Thai traditional practice was the traditional name of their space. TTM department did not use the name like biomedicine. They still used the name of herbal plants and lucky words such as *phu ngern* (silver betel), *phu horm* (fragrant betel), *phu thong* (golden betel) and others. The maintenance of identity of TTM in a hospital would represent a way of its integration in the hospital.

TTM had provided the sustainability that was constructed by patient's need and public relation. TTM practitioner tended to define the resistance in the positive action towards biomedicine by promoting the good side of the integration to the public. To resist the discursive practice of domination, TTM would be empowerment by promoting and presenting as more known. Now, TTM in the hospital is better recognized than in the past and is needed more by patients, especially in herbal medicine. So, there were some herbal medicine products stocked at the pharmacy part of biomedical space.

The influence of discursive practice of biomedical science has impacted the position of TTM. In this point, TTM practitioners tried to learn about biomedicine to enhance their power and upgrade their position in the hospital. In this study, the other form of resistance of TTM was in the form of integrated knowledge. They also pulled from alternative belief systems which balancing to construct practice as legitimate and professional health care.

Besides, TTM had transferred traditional knowledge to biomedicine practitioners to resist the power of biomedical knowledge. Now, TTM stands in the biomedical field as an important role in patient care. This form of resistance of TTM was constructed through the transfer of Thai traditional knowledge to the practitioners of biomedicine. The form of knowledge transferred and integrated involved both sides of TTM practitioners and biomedical practitioners. Biomedical practitioners, especially nurses, had accepted TTM and tried to learn about TTM knowledge because TTM service would be involved in their work. It meant that, not only TTM had influenced discursive practice of biomedicine but also biomedicine had influenced TTM knowledge too. An example statement is as follow:

"At first, TTM was not accepted by nurses. I worked in biomedicine. Now, it was part of our work. When our hospital had TTM, we would learn from them. When patients asked, we could answer them. If we could not answer patient's question, we would lose our face." (Nurse G, female – 36 years old)

However, TTM practitioners were forced with the critique from the different knowledge between biomedical practitioners and TTM practitioners. It was the encounter between different powers of knowledge. There were the results of domination discursive practice; especially the low education that made TTM in the hospital looked like the simple thing that had less knowledge. So, many biomedicine practitioners used their knowledge to criticize and used their standing point to reject. But, TTM practitioners would use their knowledge to force biomedicine practitioners and tried to deny in actions. The interactions were the discussions between biomedical practitioners and TTM practitioners about the treatments. TTM practitioners would deny this difference and tried to do as they thought that was useful which depended on their knowledge too. This was the form of resistance that depended on the standing point based on knowledge. An example statement is as follows:

"If I found nurses or medical doctors trying to point out in the different concepts from my background knowledge, I would present them with the truth that supports my TTM knowledge. And, sometimes I could not accept that and did not do as they thought if I was sure that they were not true." (TTM practitioner A, female – 27 years old)

In addition, the construction of the subject of TTM service transformed the meaning of mhor nuad to the problem of molestation. The resistance of this disrespect happened in TTM service. The massage staff had resisted by refusing to give any service to the customers who had ever molested them. Since the discursive practice of mhor nuad was dominating the position of massage staffs, it shaped the terms of massage staffs with the construction of a sexual identity. An example statement is as follow:

"Male customers molested me many times in both speech and action. I had even climbed through the window and avoided to service them. Nobody wanted to be molested." (Massage staff I, female – 42 years old)

Massage staff wanted to take pride in being health care practitioners. They tried to replace the sexual image with the show that massage was the healing using the techniques of professionalism and tried to developed professional status for their TTM practice.

Summary

For the summary, the concepts of discursive practice of TTM in the hospital could be conceptualized and shown as in the figure 3.

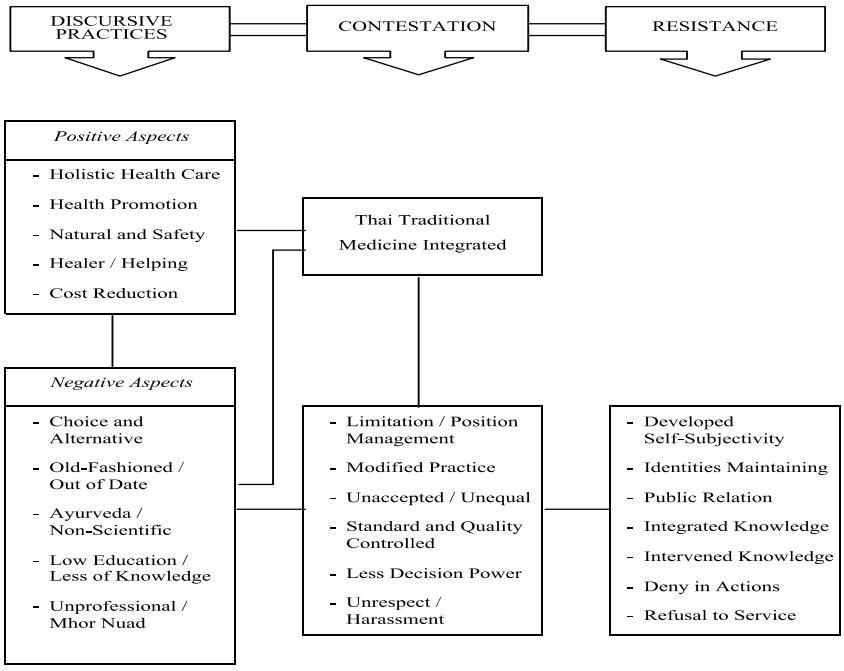

Figure 3. The discursive practice of TTM in the hospital

Discussion and Conclusion

The hospital was the key resource and center of the community health care system. Hospital not only delivered primary patient care but also trained health personnel including medical doctor and Thai traditional medical professions. In the biomedical model, only doctors know what is important for an individual's health because of their knowledge and professionalism. The doctors have thereby maintained their professional autonomy and remained the main decision makers in hospital practice (Freidson, 1988). Hospital was best known as a large employer of health workers with various medical conditions requiring diagnosis and treatment. Patients were most likely to see in their own community and to go to

hospital if they have health problems. While TTM had entered the biomedical fortress in hospital, they did not provide adequate conditions for a thorough epistemology integration of the two medical systems or even for negotiation over the doctrine of biomedicine in the hospital setting. Scientific medicine continued to exercise its power through professional field. Doctors had controlled and directed medical knowledge to determine resource and service control. They maintain a strong position and use their power to control over the hospital. The finding of this study indicated that the power of TTM in hospital was influenced by the power of discourses. The domination discourse practice controlled and constructed the lower position of TTM. It could be said that discourse was a form of power that based on knowledge and made use of knowledge. According to Foucault (1973), power and knowledge are focused in an arena of discourse. Discourse was a group of statements which provide a language for talking about social construction, constituting social subjects, social relations, and systems of knowledge and belief which considered being an institutionalized way of thinking or possible truth to controlling, positioning, and productive capacities of practices. It governs the way that made a topic of TTM provision in the hospital meaningful. People believed that TTM in hospital has better standard than outside. From the study, TTM had a lower status than biomedicine because, in social view, they did not have enough knowledge. TTM was reduced and decreased into a type of massage or mhor nuad as the villager language although it was provided in the hospital that had influenced the power relation between biomedicine personnel and TTM staff, and also between TTM staff and their patient. These groups of statement of discourse provided a language for constructive knowledge and belief that governed the way of thinking and the relation to controlling, positioning, and practicing which is meaningful.

Biomedicine was believed to be the best medical system that applied scientific knowledge and arrangement of working patterns in service. It played a pivotal role in managing and controlling the position of TTM. That was the form of power relation that made medical doctor had power to control and limit the TTM in the hospital as Foucault (1973) viewed *"Power origin in specialist's knowledge. Power is based on knowledge and makes use of knowledge to construct the truth for control."* TTM was also viewed as unaccepted, looked like superstition, and had unequal education background. The biomedical discourse of scientific knowledge had influenced the position of TTM in this hospital. In biomedicine view, TTM should develop and should have evidence based researches to support their efficiency and effectiveness. When doctors use alternative medicine or order to combine the two types of medicine, doctors necessarily need to improve the quality (Naoki, 2007). If some kind of alternative medicine has found to be reasonably safe and effective, it will be accepted (Angell & Kassirer, 1998). However, encounter between holistic discourse and biomedicine influenced the limitation of TTM service and position in the hospital. There are a large number of biomedical practitioners who question the reliability of traditional medicine (Anyinam, 1990), for example, they have consistently viewed traditional medicine practitioners as unscientific and professionally unreliable as far as biomedical standards as Shuval (1999) had cited

"Biomedical practitioners who refer patient to alternative medicine generally believe that it is an appropriate alternative if there is a good reason to believe that it could do no harm."

Foucault focused upon questions of how some discourses have shaped and created meaning systems that have gained the status and currency of truth, and domination. From the study, biomedicine still had more power than traditional medicine because it was long time fostered the scientific knowledge. Various forms of knowledge are presented in a hospital,

biomedical as well as other non-medical professional forms of knowledge such as administrative, legal, technical and so on as Geogropoulos and Mann (1983) and Amandy and Stephen (2004) mentioned:

"Although the knowledge base of each area is different in nature, it is embedded within the bureaucratic hospital system that divides the healthcare system into sub-units of operation. The functioning in the hospital fractured by the conflict between the bureaucratic systems existing within the organization by medical doctors is in a powerful position to reject any attempt to control the practice of all medical practitioners".

The power of TTM in hospital was related to the knowledge of health promotion that led to the acceptance and need. The development of TTM in order to achieve comprehensive and holistic health goals should be upheld to be a professional service. Michel Foucault identifies the way knowledge works through professional groups by establishing scientific criteria.

Besides, TTM tries to resist the domination of other discourses by mentioning the biomedical treatment and the positive actions. TTM practitioners worked at the micro level in hospital to boost their image and their form of TTM to biomedicine. They did this by using information from general traditional practices and from biomedicine. They also adapted from alternative belief systems which balance to construct practices as legitimate and offer alternative professional health care (Mychel, 2009). Although TTM is provided in hospitals, it is a subordinate system there because the ideology of TTM is distinctly different from biomedicine. Biomedicine depends on scientific method, but TTM does not emphasize this. It is clear that there is a need to create a balance power in this medical relationship. The hospital seems to be a central organization to promote this balance from which doctors and TTM practitioners could deliver medical services.

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References

Amandy, K., & Stephen, D. (2004). A question of place: Medical power in rural Australia. *Social Science & Medicine, 58*(1), 1059–1073.

Angell, M., & Kassirer, J. (1998). Alternative medicine: the risks of untested and unregulated remedies. *The New England Journal of Medicine, 339*(12), 839–841.

Anyinam, C. (1990). Alternative medicine in western industrialized countries: An agenda for medical geography. *The Canadian Geographer, 34*(1), 69-76.

Chungsathiansap, K., & Tantipidok, Y. (2007). *สุขภาพไทย วัฒนธรรมไทย* [Thai's Health, Thai's Culture]. Nonthauri: Society and Health Institute.

Cooper, R., & Stoflet, S. (1996). Trends in the education and practice of alternative medicine clinicians. *Health Affairs, 15*(3), 226–238.

Daniel, H. (2006). Uncharted ground: Patterns of professional interaction among complementary or alternative and biomedical practitioners in integrative health care settings. *Social Science & Medicine, 62*(1), 731–744.

Eisenberg, D., Kessler, R. C., Foster, C., Norlock, F. E., Calkins, D. R., & Delbanco, T. L. (1998). Unconventional medicine in the United States: Prevalence, costs and patterns of use. *The New England Journal of Medicine, 328*(1), 246–252.

Foucault, M. (1973). *Birth of the Clinic: An Archaeology of Medical Perception*. London: Routledge.

Foucault, M. (1980).Body/Power. In C. Gordon (Ed.), *Power/Knowledge*. Brighton: Harvester Press.

Freidson, E. (1988). *Profession of medicine: A study of the sociology of applied knowledge* . Chicago: University of Chicago Press.

Geogropoulos, B., & Mann, F. (1983). *The hospital and an organization*. New York: SP Medical and Scientific Books.

Gibson, D. (2004). The gaps in the gaze in South African hospitals. *Social Science & Medicine, 59*(1), 2013–2024.

Lewith, G., Kenyon, J., & Lewis, P. (1996). *Complementary medicine: An integrated approach*. Oxford: Oxford University Press.

Mychel, E. (2009). *Identities of alternative medicine practitioners*. Florida: University of South Florida.

Naoki, A. (2007). *The future issues of complementary and alternative medicine*. Japan: Fujitsu Research Institute and Economic Research Institute.

National Center for Complementary and Alternative Medicine. (2008). *The Use of CAM in United States in 2004*. United Stated: Author.

Putipun, P., Nongnuj, S., & Panjachat, R. (2012). A survey of complementary and alternative medicine use in cancer patients treated with radiotherapy in Thailand. *Evidence-Based Complementary and Alternative Medicine, 1*(1), 1-6.

Salgureo, C. P. (2007). *Traditional Thai medicine: Buddhism, Animism, Ayurveda*. United States: Hohm Press.

Sherer, P. P. (2008). *The situation of alternative medicine in Thailand.* Bangkok: Department of Thai Traditional medicine and Alternative medicine development.

Shuval, J. (1999). *Social structure and health in Israel*. Jerusalem: Magnes Press Hebrew.

Shuval, J., Mizrachi, N., & Smetannikov, E. (2002). Entering the well-guarded fortress: Alternative practitioners in hospital settings. *Social Science & Medicine, 55*(1), 1745–1755.

Srijaroenjira, N. (2003). *Alternative medicine in private hospital in Bangkok*. Nakhon Pathom: Mahidol University.

World Health Organization. (2005). *Global atlas on traditional, complementary and alternative medicine*. Kobe: World Health Organization Centre for Health and Development.

Wisutwet, R. (2007). *Thailand: Wellness capital of Asia*. Bangkok: Ministry of Public Health.

Wiwanitkit, V. (2003). The use of CAM by HIV-positive patients in Thailand. *Complementary Therapies in Medicine, 11*(1), 39–41.