

# **From Medicalizing State to Sacralizing Status of Thai Buddhist Monks in Secular Space: A Case Study of the Priest Hospital**

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## **Abstract**

This paper examines the sacred status of Thai Buddhist monks who have been engaging with the modern secular healthcare system, which also contrasts with their monastic traditions. It questions how modern medication has affected the sacred figure of Thai monks and what is their reaction to maintain their sacred status in such a secular space? Participant observations and informal interviews have been conducted, and data are conceptualized through the ideas of the birth of the clinic and biopower proposed by Michel Foucault. It finds that the traditional healing previously played by Thai monks has been challenged by modern medication eventually the monks also access the modern hospital. This phenomenon helps to change the idea of the cause of sickness, from demons to germs. This is interesting when some Buddhists request the monastic code-based healthcare system and monk patients' zone. This paper argues that such an effort aims to maintain the sacred status of monks, who are perceived as holy persons and should not be seen by laypeople especially when they are in sickness, pain, and sorrow, which portray their ordinary human natures. Therefore, zoning management in the government hospital is needed to sacralize the monks' status.

**Keywords:** Buddhism, Medicalized society, Thai Buddhist monk, Secular, Unofficial sacred space

## **Introduction**

Money donation for constructing the Patient Buildings for Buddhist monks in many hospitals has become a popular campaign for a decade in Thailand. It aims to strengthen the healthcare system for monks, who are considered the moral and spiritual teachers of this country, to access the modern healthcare system that bases its service on monastic codes. Notably, the status of Thai Buddhist monks in Theravada Buddhism is distinguished from laypeople in terms of different levels of moral conduct. Monks are prohibited by their disciplines (Vinaya in Pali Language) not to touch women with sexual desire (including female doctors and nurses), to spend a night with laypeople, to wear laypeople's clothes, and so forth.

Therefore, when the monastic practice has been strictly interpreted to preserve the monks' identity in this decade, the Priest Hospital or at least a Patient Building for Monks in the government hospital is needed, which will also be used as a case study in this paper. Previous scholarly works on medical history in Thailand mainly focused on the influence of Western knowledge on the development of public health in Thailand. Puaksom (2007) studied the development of medication and hospitals in Thailand. His finding was that not only have medical organizations been developed, but the concept of sickness and political hegemony is also changed and controlled by modern medical knowledge. Kacharat (2016) also focused her study on each period of healthcare systems in Thailand. She found that internal and external factors such as the anti-communism campaign and WHO policy affected Thailand's national public health policies. American missionaries were doctors and employed medical knowledge to drive their religious work. Interestingly, the paradigm shift of the concept of sickness from demon to germs, proposed by Muksong (2020), clearly portrays one of the turning points of medical knowledge from religion to modern science. Nonetheless, this paper argues that local Thai knowledge should not be viewed as the opposite of modern medicine in every aspect. Therefore, its integrations and responses should also be studied.

Besides historical studies, various scholars such as Tepsuriwong (2019) and Marknuan (2014) scrutinized the current role of traditional healers in rural areas. They found the challenging roles of local healers who have to respond to the modern scientific worldview. However, as one of the spiritual leaders in Thailand, Buddhist monks received less attention, even though they also play a healing role. Therefore, the status of Thai monks is undeniably challenged by Western medicine as well. As a result, this paper aims to examine strategies initiated by monks and their followers when encountering such a secular healthcare system and examine how they preserve their holy figure when they receive medication in the secular hospital.

This paper is organized into two sections. (1) Medicalizing State and Local Response: elucidates the changing history of medical worldviews in Thailand, where the traditional concept and medication have been challenged by Western knowledge, imported mainly by missionaries. From the nineteenth century to the present, Thailand has been developing healthcare systems, ministry of public health, universities for medicine, provincial hospitals, and so on, which affect the state of local knowledge and traditional healers, including monks. However, this paper also proposes that local knowledge does not distinguish itself from Western science; instead, it tends to integrate. (2) Sacralizing Thai Buddhist Monk's Status in Secular Space: continues to discuss the strategies adopted by Buddhist monks and laypeople to strengthen the sacredness of monk's status in the public hospital.

### **Theoretical framework**

Two concepts are adopted here: (1) The birth of the clinic and (2) Unofficial Sacred Space. (1) According to Foucault's idea of 'The birth of the clinic' (1973), the state tried to gaze and control people by using medical knowledge and modern hospitals. Not only the modern healthcare service is provided, but the state's ideology and control are also transmitted,

because the medication is not pure science, but combined with medicine, economics, power, and society (Foucault, 2004, p. 19). The term ‘medical gaze,’ for Foucault, means the medical separation between a patient’s body and his identity, in which people are dehumanized into an object of analysis based upon medical knowledge (Foucault, 1973, p. 165). However, power is not limited to political institutions; instead, it is constructive of all social relations, norms, and practices, working on the dominant and dominated (Foucault, 1980, p. 156).

Foucault’s idea on biopower is also employed in this paper. I agree that Thai Buddhist monks and Buddhist views of sickness are also affected by the stream of (modern) medicalization. Nevertheless, according to Foucault’s concept of biopower, the display of power should not be seen as only top-down, but also bottom-up. Therefore, individuals also have the agency to resist the state’s power. This paper portrays how monks respond to that phenomenon by creating the ‘unofficial sacred space’.

(2). Unofficial Sacred Space is employed to explain the process of transforming the government hospital in Thailand, which should be perceived as a secular space, into the sacred area, in which monk patients are under the care of doctors but corresponding to the monastic codes, as Thai Buddhists claim. Sacred space is not static but dynamic because it can be created everywhere, including in secular societies. It can always be found outside the “officially sacred” (Tse, 2014, p. 201). In addition, “unofficially sacred” spaces like individual houses of spirit mediums in Singapore can be seen as resistance to the state’s recognized religions and functionalist policies (Heng, 2016, p. 215). The idea of resistance through unofficial sacred space helps to understand better Foucault’s concept of biopower, in which the dominated, monks in this paper, have the power to negotiate and generate their sacred space.

## **Research method**

The first section is documentary research. Data was collected from academic books and journals. Then, the second section adopted participant observations and informal interviews for six months in two hospitals in Thailand: Priest Hospital in Bangkok and the Monk Patient Building in Maharaj Nakhon Chiangmai Hospital. The first place had been visited from November 2019 - March 2020. It was selected because it is the center of the monk’s hospital in Bangkok and the Monk Patient Building model in other provincial hospitals. Meanwhile, the second place in Chiangmai province was conducted in May 2013, when the researcher was a monk receiving lung surgery. In both places, informal interviews were conducted with nurses, patient monks, and laypeople who were monks’ followers. The total numbers of informants are fifteen. Ten were monks, two were monks’ followers, and three were nurses. All of them were selected from familiarity with the researcher when he was conducting the observation.

## **Finding and discussion**

### **Medicalizing state and local response**

In the middle of the nineteenth century, the Department of Royal Physicians (Krom Mor Luang in the Thai language) was established for the sake of the healthcare service of the royal families. Its way of treatment was based upon the Indian Ayurveda knowledge, in which

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health is from the balance of four elements: earth, water, wind, and fire (Puaksom, 2007, p. 313). Of course, this kind of medical worldview was a general knowledge outside the palace as well. Buddhist monks and laypeople reportedly become traditional healers in all regions. Notably, it seems that Thai traditional medicine also perceived the cause of sickness as demons. In consequence, the royal ritual of illness destruction called Apat Phinat was performed. Atanatiya Sutta, a Buddhist mantra depicted from the Pali scripture, was chanted to eradicate sickness. This ceremony was challenged by an American missionary, Dan Beach Bradley, who used modern vaccination to rescue many thousand patients from cholera in 1835 (Muksong, 2020, p. 85; Puaksom, 2007, p. 314).

It should be noted that Bradley has based his initial knowledge on miasmatic theory, in which the cause of sickness is from air and water pollutions. Nonetheless, this theory was influential in Thai public health policy in 1856, when King Mongkut (r.1851-1868) issued a royal decree to control the cleanliness of rivers and canals to prevent a cause of disease. Then, in 1901, the theory of ‘germ’ entered Thailand when Campbell Highet, an acting medical officer in the Department of Sanitation, submitted a report on the outbreak of Glasgow Bubonic Plague. However, George McFarland fully articulated it in his publication ‘Manual of Plague Preventions and Treatments’ in 1910. The germ theory has eventually been taught in Siriraj Medical School since then. McFarland could also explain how the germ enters human blood and causes plague (Puaksom, 2007, p. 320, 328).

One of the turning points of medical ideas in Thailand can be traced to 1889 when the medical school named Siriraj was established in Bangkok under the patronage of King Rama VI. As discussed above, it is the product of Western knowledge (Kacharat, 2016, p. 22). This period is interesting because since the period of King Rama IV, some elites began to criticize the efficacy of Buddhist mantras and local rituals in eradicating diseases such as cholera. Of course, the role of Buddhist monks and magical healers has been reduced by modern sciences, which was undoubtedly imported by the American missionary doctors, though their religious knowledge was resisted by some Siamese elites (Winichakul, 2015, p. 78). In order to attract people to the modern healthcare system, King Rama VI also provided some money for those who gave birth in the government hospital (Kacharat, 2016, p. 23).

It can be said that Thai people can easily access to public healthcare system after political reform. In 1932, Thailand changed its state from absolute monarchy to democracy. Pridi Banomyong, leader of the revolution group, initiated the project to construct government hospitals in every province. Moreover, the area of Thung Phaya Thai in Bangkok would become the city medical complex. However, this project was canceled due to political disability. In 1942, Thailand also initiated the Ministry of Health in order to promote the nation-building policy. During this period, the Priest Hospital was established in 1949, in which the project was initiated by Field Marshal Plaek Phibunsongkhram, the third prime minister, alongside the project of constructing hospitals in every province (Kacharat, 2016, p. 24).

Under Sarit Thanarat’s regime (1959-1963), the threefold ideology: nation, religion (Buddhism), and monarchy, was promoted as nationalism. More interestingly, to eradicate communism, a group of doctors has been set up and sent to red-zone areas. This project aimed

to prevent people from communism, while the government's medication was easy to be accessed. Although communism has gone, this foundation has been going on. King Rama IX always traveled to rural areas with those doctors. In so doing, he gained familiarity and popularity. According to Saengkanokkul (2016), this project becomes a tool to promote the monarchy alongside modern medication. It cannot be denied that public health is one of the various sources of political legitimacy in the sense that the leader can claim his compassion-based authority, in which the lives of people are the priority. This claim is valid in an absolute monarchy like Jayavarman VII, king of the Khmer Empire, who initiated traditional hospitals (Arogyasala) for his people (Yemdete, 2015, p. 174), and democracy like public health policies in Thailand after 1932.

Simply put, developing and implementing modern sciences can be seen to show the Western authority in Siamese modernization. Meanwhile, the state can control its citizens through the concept of power and the healthcare system. However, it should not be seen that there is no space for traditional medicine. In contrast, it is still needed, especially for those not satisfied with the hospital service. Even though such kind of local wisdom is in decline, as claimed by many scholars, there are some efforts to restore, preserve, and integrate it with modern medicine. So, the development of local medication and its responses should be mentioned here.

Motham or traditional healers in Northeast Thailand are magical specialists who use mantras and herbs in medication. According to Supsin et al. (2018, p. 304), nowadays-Motham still has to deal with various patients, suspected of being possessed by a ghost or black magic. At this stage, it can be said that the local concept of sickness caused by a demon still exists. Nevertheless, Motham's medication process is complicated and mixed with different tools such as mantra, trance, herbs, music therapy, and so forth. Interestingly, patients are recommended to receive medication from the hospital as well (Supsin et al., 2018, p. 308). This study reveals the integrity of traditional and modern healthcare systems. Notably, Motham can be male, female, transgender, as well as Buddhist monks. Its knowledge usually is orally transmitted from one's parents but can also be learned from the healer (Marknuan, 2014, p. 97).

Undeniably, the Thai traditional healing has been Buddha-ized in many aspects. The status of the healer is considered holy because he or she performs a medication ritual in the name of spirits or previous teachers. Therefore, some behavior requirements such as to strictly practicing the Buddhist Five Precepts are needed. Some also conduct fasting once a week. Laypeople can be viewed as like-monk healers in this regard. Of course, the first mantra to be chanted during medication is Namo Tassa, to worship the Buddha (Marknuan, 2014, p. 106; Puriwanchana, 2018, p. 83). This method is sometimes called syncretism; however, many people do not feel alienated or distinguish each part of the ritual into Theravada and non-Theravada practices. More interestingly, when the patient is recovered, he or she will be told to donate some money or food to monks, to make merit in the Buddhist tradition. Besides villagers, Buddhist doctors and nurses still view Buddhist teaching important in the medication process. A group of educated monks called Gilanadhamma, was initiated in 2008 in Bangkok. Those monks are trained and invited to talk with patients in hospitals for mental therapy. It can

be said that religion should not be viewed as the opposite of modern science. In many cases, the patients also need the spiritual dimension of healthcare. The value of the relationship between the patient and the nurse in a healing environment is emphasized in various countries (Fournier, 2017, p. 110).

The case study of Venerable Samrit portrays the integration between local and modern knowledge. As mentioned above, scientific knowledge seems to falsify religious ideas of demons as a cause of sickness. Samrit, a Buddhist monk and traditional healer, gave an interview in March 2020 that he also believes in germs. According to him, different diseases are caused by germs; therefore, traditional herbs are provided to deal with germs. However, he continued, herbs and modern medicines alone have less power to deal with sickness in the body, in which the human body is generated from spirit or mind. Therefore, the mantra is needed to fill this gap. Of course, he does not deny modern medicine. In contrast, he recommends the patients see the doctor first. Interestingly, many people give him their modern medicine for the sake of chanting some mantras before consuming.

However, the healing role of monks is in decline when Buddhism in the modern world, in some sense, has been redefined as the emphasis on the Pali texts, rather than traditional culture as practiced before. This means that monks have to be in line with the monastic codes. Monks are expected not to perform the laypeople's careers or magical specialists like traditional healing and fortune-telling, as suggested by a Buddhist scholar named Payutto (2014, p. 2). In addition, for the sake of wisdom development (Panna), according to modern interpretation based on the Pali text, the monastic codes (Sila) and meditation (Samadhi) are needed. The trend of meditation practice raised in 1950 in Theravada countries is a piece of evidence to reaffirm the new definition of authentic Theravada Buddhism (Schedneck, 2012). In Thailand, the Training Meditation Teacher Program was initiated in 2003 under the king's patronage. This program is aimed to train monks in Vipassana meditation to teach laypeople the proper meditation, according to the mainstream way of Theravada point of view.

Puaksom (2007) employed Foucault's idea to analyze medication development in Thailand in the nineteenth and twentieth century. He proposed that Thailand in those periods was medicalized because citizens were encouraged to consume healthcare ideology and services from the state. Based on modern medication influenced by Western science, the well-being of people was emphasized for the sake of developing the country; eventually, it can be said that the nation-state of Thailand partially occurred because of the medical revolution. So, not only the modern healthcare service is provided, but the state's ideology and control are also transmitted because the medication is not pure science, but the links between medicine, economics, power, and society (Foucault, 2004, p. 19). The following section will describe how the authenticity of being Theravada meditative monks is essential and how the Priest Hospital helps preserve the monk's sacredness.

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### **Sacralizing Thai Buddhist monk's status in secular space**

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The Priest Hospital's construction project was begun in 1949 and done in 1951. Its location is the king's property. Before the construction, the project had been published in eleven national newspapers for months and ultimately received THB 1,162,632 (USD 35,629) of financial donation (Priest Hospital, 2019, p. 86). In 1951, the hospital committee transferred it to the National Department of Medical Services under the Ministry of Public Health. Although Buddhists started the project with donations as a private hospital, they finally converted it into a government hospital, in which the state has to provide an annual budget to it similarly to other government hospitals. Three objectives of the Priest Hospital have been revealed since the very beginning, namely: (1) to avoid the inappropriate services that monks and novices must be treated in the laypeople hospitals, (2) to facilitate good healthcare services to monks and novices based on the monastic codes, and (3) to follow the Buddha's teaching "he who wants to take care of me, he should take care of the sick monk instead" (Priest Hospital, 2019, p. 85).

According to the annual report in 2019, the Priest Hospital consists of 278 beds, provides services for 5,000 inpatients and 80,000 outpatients. Its service is flexible. Ven. Khantiko gave an interview in January 2020 that he traveled from Ayutthaya province, 80 Kilometers from the north of Bangkok to see the dentist. Unfortunately, the dental service was not available on that day. Surprisingly, the hospital official treated him as a patient, though he had not seen the doctor yet, and allowed him to rest there for a night. In Ven. Khantiko's opinion, this is a good service provided by the Priest Hospital for monks from rural areas. Dental care in government hospitals costs some but it is free in the Priest Hospital for monks and novices.

The Priest Hospital's organizational culture is that "coming to work is also making merit," while the Buddha's word in Vinayapitaka Mahavagga No. 116, "he who wants to take care of me, please take care of the sick monk" is used as the motivation sentence. This quote is one of many reasons to separate monk patients from laypeople in order to provide them the appropriate healthcare system as interpreted by Thai Buddhists. However, some new interpretations can be found. The Buddha said the above sentence to monks and recommended that they must take care of each other. Nonetheless, when Buddhism came to religious states, Thailand, for example, this saying has been treated as if the Buddha recommended laypeople take care of monks and the great merit will be gained as equally as they take care of the Buddha himself. Moreover, the state should dedicate its budget to accomplishing that goal.

The belief that laypeople should take care of the sick monks seems to reflect the problem in the monastic life itself. Initially, the Buddha designed the relationship among the monk members by helping each other, meaning that when the master is sick, his students must take care of him, and vice versa. This monastic structure was gradually destroyed when the monks were strongly involved with the state's power, consuming the high-ranking status and having close relationships with the wealthy lay devotees. When those monks are sick, they will be surrounded and looked after by lay devotees, and of course, they will also be sent to the famous hospital. In daily life, those famous monks are very busy providing services to the laypeople until they have no time to take care of their sick student monks. This kind of broken

relationship also leads to the problem of an aging society in the monastic life, in which the old monks must be alone, because the monks' lifestyle seems to be more individual. Therefore, the lucky monk is the one who has already generated connections with lay-devotees; of course, his high ranking, educated, and charismatic statuses are key conditions.

The concept of a special place of monks' dwelling or Sanghavasa is a new thing that happened after the Buddha's passing. Its primary purpose is to separate the monks' space from the laypeople. The big monasteries in Thailand always identify the name of such and such zones; for example, Buddhavasa is used for ritual performances, while Sanghavasa is for monks' dwellings. In consequence, laypeople, especially women, are generally not allowed to enter the second area. Of course, some monastic codes could be traced in the Pali canon; for instance, monks should not sleep in the same place with non-ordained ones, including novices, and a woman should not be in the same place with a monk without the third person. Based on these practices, the special space for monks, including hospitals, may develop in a Buddhist country like Thailand (Dhammajito, 2019, p. 92; Artsanthia & Techakuljareon, 2019, p. 32).

Scholarly works on the monk's healthcare in Thailand always mention that monks should be separated from laypeople because monks are also not considered as ordinary people, but they have a higher level of morality and social privileges (Bunthong, 2017; Pornprasert et al., 2016; Artsanthia & Techakuljareon, 2019). Even Patcharuch Onto et al., (2019), who initiated application Sukpra (monk's happiness) to strengthen the healthcare system, also declares the same reason. According to an interview with nurse B in January 2020, if the sick monks are in the same place with laypeople and express some emotions like being angry during medication or crying out due to physical pain, laypeople's faith in monks may be fading. Therefore, she also agreed to provide separate zones.

Ven. Paisan Visalo, a famous meditation master and environmental activist monk, said that hospitals' officials have to learn patients' different cultures and beliefs and treat them based upon their backgrounds. Otherwise, the way of service of the hospital will marginalize someone from the state's service (Dhammajito, 2017, p. i). Visalo's saying is still based on the aspect of a religious state. Of course, the state should respect multiculturalism as long as that kind of respect does not violate other people. The following question is, how about the Muslim patients who ask for halal food and also claim that their food should be cooked by Muslims only? Must the government respect such demand by recruiting only Muslim workers in that hospital? The following examples may help to clarify this religious idea.

Dhammajito (2017, p. 20) writes that some monks deny the healthcare service in public hospitals because they were treated as laypeople, making them break the monastic codes. This belief should be questioned whether the monastic life designed by the Buddha 2,500 years ago is not up-to-date or invalid for today's practice? Of course, the Buddha also allowed monks to adapt their livelihood according to the new context, but it becomes the obstacle of Theravada tradition, a sect that claims the originality of early Buddhism and will not adapt or change any rule. This is just a discourse. From the past to present, we witness Thai monks adopt various practices such as the purpose of monastic life not mainly focusing on enlightenment (Nibbana), but rather to elevate their social statuses, access educational opportunities, and many of them



are also involved in ecclesiastical status, receive money donated by devotees as well as salaries from the government, and so forth. It can be said that all kinds of adaptabilities can be allowed as long as the monks still maintain the worshipful privilege status. In contrast, whenever they have to adapt and become equal with other citizens, that is unacceptable.

In practice, Thai monks who strictly follow the monastic code cannot sit on the same seat (at the same level) as laypeople, especially women. They also cannot stay in the same room with women, including doctors, needless to say about physical contact with women. It means that the state should provide the special seat (also in bus stations, airports, and so forth), while the male doctors are preferred or at least a male should be with a monk during medication (Dhammajito, 2017, p. 30). Notably, this kind of strict interpretation is found in Thailand only; Theravada monks in Myanmar, Sri Lanka, and so forth do not hesitate to touch women, especially in the public sphere, because the monastic code prohibits monks from having body contact with women (also men) with sexual desire only. So, monks in those countries do not have any problem receiving healthcare services from female doctors. Moreover, in public hospitals in Thailand, if the time is going to be eleven o'clock, the hospital's officials are suggested to accelerate the process by serving the monk first, though many laypeople are in the queue. That is because the monk must have lunch before noon. Nonetheless, it should not be assumed that all monks are happy with this unfair service; though they are treated with some privileged methods, they have no choice because it is the hospital policy suggested by the religious state through the Priest Hospital's campaign. Therefore, to provide good services, based on the interpretation of conservative Buddhists, Priest Hospitals must be constructed.

According to the interview with Ven. Thanissaro, the significance of zoning management is evident. Thanissaro went to the Priest Hospital in December 2018 and mentioned that he got THB 600 (USD 18) from a one-day stay. Three groups of devotees gave the patient monks some money and fruits in the afternoon. He added that the hospital also allowed monks to have dinner on the ground that some monastic codes should be adapted/ignored because they were in sickness. This case clearly shows that Thai monks and laypeople are also flexible in monastic practices. However, having dinner of monks should not be seen by laypeople, so private spaces such as the Priest Hospital in Bangkok and the Monk Patient Buildings in other provinces are needed in this sense.

Besides the support from the government's budget, the Priest Hospital gains many donations in terms of money as well as medical materials until it can perform the transnational services, such as checking the health conditions of Thai laborers and missionary monks in India, Korea, and Malaysia (Priest Hospital, 2019, p. 54). It also published many thousands of books on healthcare and distributed them to temples. One of its monthly activities is to donate i and medicine to some temples in Bangkok. Interestingly, on April 29, 2020, the post on its Facebook Page mentioned stopping receiving any material donation because the stock was full, while other government hospitals still need a lot of medical objects. This phenomenon reveals that Thai people may prefer to donate to monks on the ground that it can produce many merits and intensify the Buddhist identity.

Nowadays, twenty-two hospitals in many provinces have been certified as an excellent center for monk service based upon the Buddhist monastic codes approved by the Priest Hospital and signed by the National Department of Medical Services (Priest Hospital, 2019, 67). In order to approve that quality, the Priest Hospital provides some seminars on “how to take care of the monks” and encourages provincial hospitals to build a new building to separate monk patients from laypeople.

However, some weaknesses in healthcare services in the Monk Building of the Maharaj Nakhon Chiangmai Hospital should be noted as an example. According to the interview with Ven. Silanandho, on March 24, 2013, he had been in the hospital for two weeks with the pneumothorax symptom. He said that after an x-ray, he was told to wait for an operation for a few days. However, as a monk, he was sent to the Monk Patient Building, which is a little bit far away from the laypeople’s building. He had been looked after with respectful behaviors by female nurses there. However, after his five-day operation, the doctor never visited him, which was unusual because he was in a very serious condition. A nurse told him that the doctor was busy and that the building was far away from the doctor’s workplace. Then, he asked permission to move to the laypeople patient building in order to have more opportunities to be visited by the doctor when the doctor visited other patients, but he was denied on the ground that monks have their building, cannot be allowed to share the room with laypeople. He finally decided to move to another private hospital.

Ven. Silanandho also added that the Monk Patient Building in the Chiangmai Hospital also has VIP rooms, but only available for famous and high-ranking monks. However, the VIP rooms in the Monk Building were also not often visited by the doctor. In his opinion, the Monk Patient Building was fit for those whose condition was not severe and using that place for rest only. The case of severe symptoms was not recommended. Notably, those monks who use the Priest Hospital’s and the Monk Building services are generally ordinary monks, while the high-ranking abbots and educated monks, who have devotees, will hold the expensive healthcare insurance, so that they will go to the good (and usually private) hospitals. However, it cannot be denied that the Priest Hospitals and the Monk Patient Buildings in many provinces open more opportunities for the poor monks who cannot access a better healthcare system.

According to my experience as a patient monk in the Monk Patient Building in 2013, I was persuaded by a male nurse to participate in the group-chanting ritual under the provided reason “you can perform the monastic activity even though you are in hospital, and this meritorious action will help you to get well soon.” It can be said that some monks and nurses still believe in magical power, alongside modern medicine. However, the Priest Hospital and Monk Patient Buildings in public hospitals have a sense of sacred space or monastery due to some religious practices as mentioned above.

Does the Priest Hospital open for all Buddhist monks? Of course, no, because the patient must have the monk certificate issued by the head monk of each district, according to the state administration. If the patient is a foreigner or got ordination from abroad, he must pay the total price. It means that monks who are from the new religious movements such as Santi Asoka, the sect that the Sangha Supreme Council of Thailand has denied, cannot access the

Priest Hospital's service on the ground that their status, according to the Thai state, is considered as laypeople. Of course, they can go to the government hospitals as other Thai citizens do.

Similarly, female monks (bhikkhuni) and nuns whose statuses are still identified as laypeople in their identity cards cannot access the Priest Hospital. Compared to Myanmar, one of the countries that promote Buddhism as the state religion in the constitution, it also has the Priest Hospital, called Wachet Jivitadana Sangha Hospital, located in Sagaing, 20 kilometers from the south-west of Mandalay. Interestingly, this is the private hospital established by Ven. Sayadaw U Lakkhana in 1984. It is a 50-bed hospital that provides low-cost health services to laypeople, while it is free for monks and nuns. Notably, the status of nuns in Myanmar is better than in Thailand. Meanwhile, this private hospital also serves the nuns, but the Priest Hospital in Thailand does not. This case clearly shows the religious and social inequalities of the Thai state. In fact, all citizens must be treated equally by the state, including healthcare services. In so doing, the state will be free from the domination of religion and vice versa, called secularism (Alzate, 2017, p.32; Marbaniang, 2011, p. 11).

When monks try to be in line with the scripture, at least in the public sphere, they are also expected to show the extraordinary characteristic of those who clearly understand the truths of life. This means that monks, who teach laypeople not to attach to worldly conditions, should not be sad when they are in loss, sickness, pain, and dying. Therefore, the anger and crying of sick monks should not be seen by laypeople. In addition, although monks accept modern healthcare services, meaning that they are also ordinary human beings, they negotiate to have their own space. This phenomenon can be compared to the monarchical family members because even though they are healed in the public hospital, their rooms are special and unavailable for others. This privilege portrays not only social status but also the sacredness of the royal members and monks. In this regard, the Priest Hospital can be seen as 'unofficial sacred' that monks and lay-Buddhists have generated to negotiate with modern medicine and the secular sphere (Tse, 2014, p. 201). It is similar to individual's houses of spirit mediums in Singapore, where some religious groups, outside the state-recognized religions, open their houses to perform rituals in the private space. Due to the rituals, their homes temporarily became sacred spaces (Heng, 2016, p. 215). The idea of resistance through unofficial sacred space helps to understand better Foucault's concept of biopower, in which the dominated, monks in this paper, have the power to negotiate and generate their sacred space in the public hospitals as well.

### **Conclusion and suggestion**

In this paper, the development of medicine since the nineteenth century has been employed as a starting point for the changes in medical knowledge and the public health revolution in Thailand. The state gazes and controls its citizens by rising of hospitals, while Western scientific tools also challenge the local belief on the cause of the sickness. However, negotiations and integration from the locals can be found. One example is the case of Ven. Samrit accepts the idea of germs but interprets the body as consisting of spirit or mind. As a

result, Buddhist mantras are needed to deal with spirits of illness and to empower modern medicine's efficacy.

Thai Buddhism is challenged as well, in which monks are expected to be strict in monastic disciplines. Therefore, the careers of laypeople and magical specialists such as fortune-telling and traditional healing should be avoided. Monks tended to be more involved with meditation until the Training Meditation Teacher Program was initiated in 2003 to promote insight meditation (Vipassana), which is defined as an authentic doctrine of Theravada Buddhism. Of course, meditation is not new, but its campaign corresponds to one of the new identities of Thai monks. Meanwhile, the monastic disciplines (Vinaya) are also emphasized by the gaze of Buddhists themselves and the state. In consequence, to interpret the monastic practice more strictly is valid in the sense of strengthening the Theravada identity and paving the way to the coming of the Priest Hospital, separated from the laypeople's zone.

The status of holy monks (and royal family members) gains privileges in Thailand, a non-secular and non-democratic country. Monks in sickness, pain, sorrow, fear (of death) should not be seen by laypeople who worship monks as holy persons because those pictures will reveal the human characteristics of those who are not well-trained in meditation and Buddhist teaching. This means that Thai monks who are successful in meditation must be neutral or happy even in bad situations. Therefore, zoning management by separating monk patients from laypeople is necessary. Interestingly, although monks agree to enter the government hospital, which can be considered a secular space, they generate unofficial sacred space by using some monastic practices as they do in monasteries. Simply put, the Priest Hospital in Bangkok and the Monk Patient Buildings in provincial provinces portray the importance of the monks' healthcare system, which is supported by the government and implies the strategy of Buddhists in preserving the sacred status of monks in secular places.

In terms of suggestion, this paper does not trace the transition of monks from the healers to be patients under the modern medication themselves, of course, even though a several monks nowadays are still the healers. This piece of Thai history is also fascinating because it will reveal monks' context to ignore traditional healing and gradually pay attention to modern sciences. Future research should scrutinize it as well. Second, this paper argues for the state's neutrality in public hospitals but is not dedicated to dealing with it. If the modern (also secular) state claims to treat people equally without religious discrimination, how should it deal with the issues of respecting various identities in the government's places, like a hospital. If the minority Muslims in Thailand ask for halal food, must the government provide them with what they require? Similarly, in Indonesia public hospitals, if a Hindu or Buddhist asks for a vegetarian meal, should he deserve it, by the government's support? If the government denies it because religious belief should be in a personal space, is it counted as non-respect to multiculturalism? Therefore, this kind of dilemma should also be discussed by the future research.

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