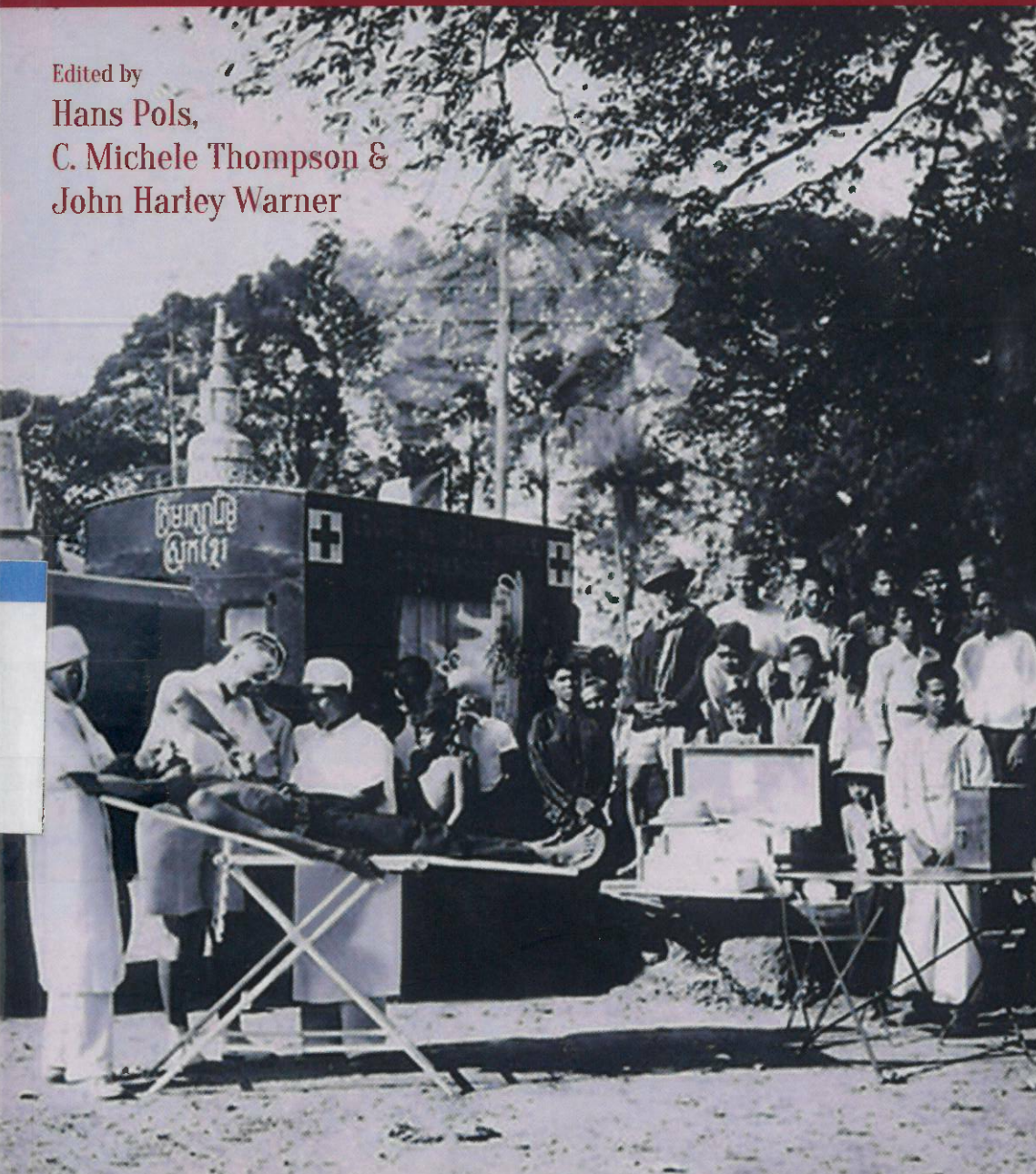
TRANSLATING THE BODY

Medical Education in Southeast Asia

Edited by
Hans Pols,
C. Michele Thompson &
John Harley Warner



HISTORY OF MEDICINE
IN SOUTHEAST ASIA

TRANSLATING THE BODY

The *History of Medicine in Southeast Asia* Series promotes academic research in all aspects of the history of medicine and health in Southeast Asia from the ancient to modern times. In order to foster closer fellowship among medical historians and greater cooperation among scholars and students, especially those practicing in the region, it provides a forum for the international exchange of research on various topics from the history of traditional medicine to the postcolonial fate of biomedicine in the region. Both monographs and edited volumes will be considered.

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Hans Pols, C. Michele Thompson & John Harley Warner

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INTRODUCTION

Translating the Body: Medical Education in Southeast Asia

John Harley Warner, Hans Pols and C. Michele Thompson

Medical education has at its core the acquisition of a new culture. Students trained in biomedicine today, for example, can attest to how becoming a physician involves not only mastering new knowledge and technical skills but also a fundamental transformation in values, affect, and identity. Students and teachers alike commonly refer to the first year of medical school as above all a matter of learning a new language. New explanatory frameworks for understanding the body cast in this new idiom can, in turn, set them apart from the interpretive frameworks held by others who have not been initiated into the healer's culture, including patients. Medical education, accordingly, involves fundamentally a kind of cultural translation, practiced not only in transactions between teachers and students, but also between doctors and patients, and between public health officers and the wider populace targeted in public health education campaigns.

Receiving a European- or North American-style medical education in late-colonial or postcolonial Southeast Asia was until recently an even more profoundly transformative experience, as conceptions of the body rooted in the beliefs of Western science often differed significantly from indigenous knowledge and commonly held explanatory frameworks. At the same time, for European and North American medicine to be embraced even selectively by the general population, modern conceptions of the human body needed to be translated into local languages and related to vernacular views of health, disease, and healing. This process of medical translation developed in the context of colonialism, which

sought to remake colonized societies in a multitude of ways. "In the colonial context the universal claims of science always had to be represented, imposed, and translated into other terms," Gyan Prakash has argued. "Translation in the colonial context meant trafficking between the alien and the indigenous, forcing negotiations between modernity and tradition, and rearranging power relations between the colonizer and the colonized."[1] So too, Vicente Rafael has highlighted the effects of colonialism and power differences on translation in general, calling translation "a kind of conquest" that irrevocably transforms the recipient language.[2]

The effects of such translation efforts have varied, depending on the strategies employed by both Western-trained health care professionals and local healers; prevalent perspectives on health, disease, and the human body; generally accepted healing traditions; and common health behaviors. The contributors to this volume chart and analyze the organization of Western-style medical education in Southeast Asia, public health education campaigns in the region, and the ways in which practitioners of what came to be newly conceived of as "traditional medicine" organized themselves in response. Medical education and public health education were part of larger processes of social change initiated during the colonial era and continued after independence—processes that involved transmission, assimilation, and transformation.[3] These efforts had significant but often unpredictable effects on local understandings of health and hygiene, practices around the care of the human body, and the organization of health care.

We use "translating the body" as a shorthand to call attention to the processes through which medical ideas, practices, and epistemologies are formulated in pedagogical contexts, selectively taken up, and sometimes refashioned, processes involving both interpretation and transmission. Translation, regarded in this way, is a linguistic but also a cultural operation, and in approaching medical education, we follow recent work in translation studies that underscores the translation not merely of words but of cultures. As one literary critic has put it, "translation necessarily marks the border crossing where, if anywhere, one culture passes over to the other, whether to inform it, to further its development, [or] to capture or enslave it."[4] Translation from one language into another played a particularly prominent role in colonial and early postcolonial medical education in Southeast Asia, as medical teachers, practicing healers, and public health officers translated Western medicine into local vernaculars for students, for patients, and for wider publics.

At the same time, it is important to recognize that the work of translation did not rest solely with teachers.[5] The instruction of Malay-speaking students in Dutch, or of Vietnamese students in French or Russian, for example, placed the lion's share of the linguistic work of translation on the students. More than this, translating Western medical ways of knowing, explaining, and managing the body in sickness and in health is best seen at the level of culture more than of language per se—the translation of cosmologies. Differences in words were but the most immediately legible sign of the deeper work involved in transmitting across cultures modes of thought and a new medical lexicon for reading the body.

In this volume, we bring together 11 contributions that analyze how medical knowledge and pedagogic methods which originated outside Southeast Asia were selectively taken up and creatively transformed in the training of physicians, nurses, and midwives as well as in public health education campaigns. Spanning the late-colonial to postcolonial periods, they illustrate the long history of pedagogic ideas, practices, and institutions, drawing attention not only to the profound changes catalyzed by decolonization but also to continuities in medical education even across times of rapid social and political change. They underscore the many ways in which students acquired attitudes, skills, routines, and professional identities that were derived partly from models of medical education originating in Europe and North America. They analyze not only the circulation of knowledge but also the transfer and transformation of educational practices that were central to teaching medical insights and their application under new circumstances. The concept of education often carries value-laden connotations, which include a sense of high purpose, moral transformation, and *Bildung*. While we do not want to dismiss those meanings of formal education in the transmission of ideas and practices regarding health, healing, and the body, we want to be explicit about looking beyond them. Throughout this book, our ambition is to blur the boundaries among education, school learning, apprenticeship, promotion, advertising, and propaganda.

We have accordingly embraced a broad concept of education that emphasizes the wider circulation of health beliefs and practices in the many different societies that comprise Southeast Asia. Our concern is with both the shaping of health practitioners and the fashioning of health citizenship.[6] The contributors in this volume pay attention to the multiplicity of vehicles for education, which include formal training programs, classroom and clinical teaching, apprenticeships, journals,

textbooks, newspapers, and advertisements; the promotional techniques of public health campaigns that sought to change health attitudes and health behaviors; the daily work of doctors, nurses, midwives, and veterinarians who served as selective cultural conduits; and the advertising and selling of health products in pluralistic medical marketplaces. As we approach it, medical education comprises all the means through which people were persuaded to think differently about their own bodies, their ailments, and the relationship between their health and their environments, and in particular how they were induced to change health behaviors (such as self-treatment, choice of healers and therapies, and disease avoidance practices). The concern here is with the multitude of ways in which the body has been translated, the transformative effect of translating into local linguistic and cultural idioms, and the difficulties translators and interpreters often encounter.

The Selective Transmission of Medical Precept

Western physicians often believed that in order to bring about health improvements, colonized populations had to be educated in the principles of health and hygiene as well as to change a variety of everyday behaviors. They assumed that, in the process, their audience would abandon what they regarded as outdated folk beliefs and superstitious ideas in favor of modern, scientific understandings of the body. The first generation of historians to study medical education and the transmission of Western medical and scientific insights to colonized populations tended to apply a diffusion or deficit model, which viewed the transfer of Western ideas as a one-way process.[7] More recent research by historians of medicine has demonstrated the inadequacy of the diffusion model to describe the process of educating colonial subjects about the body, and has revealed the vastly more complex processes at play.[8] Both at the popular level and, at times, the professional level as well, Western ideas interacted with a rich variety of indigenous medical traditions. At the same time, Western ideas on health, disease, and the body changed over time and were far from monolithic, and British, Dutch, French, American, and Soviet approaches to health and medicine, each with its own specific character, were not uniform in the medical lessons they sought to transfer to the region. Each set of ideas placed emphases differently and entailed various models of health education and ideas about the organization of health care. The interaction of these different sets of Western concepts and approaches common in the many different

areas in Southeast Asia led to a multiplicity of ideas about health, disease, and the body.

The prominence of indigenous medical teachers in colonial and postcolonial Southeast Asia and the centrality of the role they were expected to play in promoting imported medical ideas and practices draws attention to the people they were intended to teach, and the medical education of the wider Southeast Asian population is a prominent theme explored in this volume. Within the history of medicine, three historiographic movements have, in particular, encouraged this focus. One is the deliberate move away from passive diffusion models for the transmission of medical beliefs and practices, supplanting the notion that good knowledge tends to move to where it is needed with models of active transmission that emphasize the agency of individual people—gendered, raced, classed, and sometimes vocal—who selectively took up some medical precepts while actively rejecting others. Another is the impulse to re-write the history of medicine from the patient's perspective, both to understand the experience of illness and health care and to explain how and why popular health ideas, behaviors, and expectations have changed over time. And a third is the growing recognition that any understanding of the cultural authority of biomedicine must pay close attention not only to transformations in scientific knowledge and choices made by states, the medical professions, and philanthropic agencies, but also to the appraisals made by diverse subjects and citizens who held the power to convert claims to possession of particular kinds of medical expertise into authentic cultural authority.

These three historiographic maneuvers inform the questions that the contributors to this book ask about the wider medical education of the Southeast Asian populace. How did not only specific health precepts but also wider ideas, epistemological commitments, and practices regarding maintaining health, preventing disease, and curing illness circulate, and how were they transformed in the process? To what extent can changes in medical belief and behavior be mapped onto larger political, social, cultural, and economic transformations, including programs for development and modernization? How and why did the educational credentials of European- and Western-trained indigenous healers translate (or fail to translate) into cultural authority? And what was the role of other indigenous healers in this process of translation that was itself an educational initiative? What were the multiple vehicles for health education—especially the daily work of doctors, nurses, midwives, and

veterinarians who served as cultural conduits; the selling of health products and ideas alike in pluralistic medical marketplaces; popular health lectures, newspapers, journals, advertisements, films, and the vast array of promotional techniques of public health campaigns? And how did they operate in everyday life? How was it that people came to think differently about their own bodies? How are ideas about health and the body related to the developmental aims of newly formed states?

The first historical studies of medicine in the colonies tended to emphasize the heroic efforts of Western physicians who, sometimes risking their own lives, discovered the cause of tropical scourges and found ways to implement preventive measures to safeguard the lives of colonial administrators, soldiers, traders, and, at times, indigenous populations. Narratives of the role of Walter Reed in discovering the role of the mosquito vector in the transmission of yellow fever by conducting risky experiments on his soldier-volunteers in American-occupied Cuba is a proverbial example of this genre.[9] Sanitation measures helped the Americans succeed in building the Panama Canal; later, it was said that "the canal had been dug with a microscope."[10] In these early accounts, hardly any attention is given to medical education. The physicians who arrived in the areas to be colonized were fully prepared—at least so it seemed—and they did not even contemplate educating the inhabitants of the colonies about the principles of medicine as they saw them. In the 1980s, partly because of the influence of the work of Michel Foucault, the role of medicine in the colonies began to be analyzed as part of a larger project of civilizing, disciplining, and controlling colonial populations. In one of the first collections exploring the role of Western medicine in colonial empires, for example, Roy MacLeod characterized medicine as "an instrument of empire" and "an imperializing cultural force"; investigating its role, he claimed, could shed light on "the experience of European medicine overseas."[11] In most of this early research, the inhabitants of the colonies only appeared as the objects of Western medical intervention—either acceding to it or finding creative ways of circumventing unwanted hygienic measures. Why they at times embraced Western medical interventions and at other times rejected them was not examined much further in these early studies. More recent works such as that of David Arnold, Cristiana Bastos, Mariola Espinosa, Annick Guénel, Ann Jannetta, Laurence Monnais, Steven Palmer, C. Michele Thompson, and Megan Vaughan, have examined precisely this question but without extended discussions of the place of medical education, in its myriad forms, in the translation of medical ideas and ideals.[12]

Vernacularization and the Ambitions of Education

Closely situated in time and place—focusing on the Philippines, Indonesia, Malaysia, Thailand, Laos, Cambodia, and Vietnam—the chapters in this book are insistent about the specificity of local cultural contexts and meanings. Rightly eschewing a universalizing, homogenizing depiction of Southeast Asian medical education, they all situate their local stories on an international stage, underscoring the relationship between individual colonial and national experiences and wider regional and Western influences. Juxtaposing and comparing these case studies draws attention to similarities born of a shared geopolitical place in the world while simultaneously providing a heuristic that helps to reveal the fundamental role of local contexts, interests, and meanings.

Without positing some pan-Southeast Asian experience, taken together the chapters do begin to suggest historical patterns and historiographic approaches to the circulation and exchange of ideas and practices regarding health, disease, healing, and medicine across the region. In the case studies presented, language played a particularly significant role, as historical actors have often debated in which language to provide medical education, and changes in the language of medicine often reflect broader political changes. Travel also looms large—both the role of travel in the professional formation of medical practitioners and the selective way in which medical ideas, models, epistemological commitments, and practices moved.[13] The cultural, economic, and political interests that informed medical and health education initiatives also emerge as a persistent theme, with focused local studies showing, for example, how medical education served the larger aims of nationalism, modernization, development, and international diplomacy.

Language was a persistent challenge for Southeast Asian medical education programs, both as a practical matter of access and as an important ideological marker of social, cultural, and political alignments and commitments.[14] Colonial powers promoted medical instruction in Dutch, French, Spanish, or English more often than in the vernacular. Even in initiatives that sought to bring about wider access to health information by using local languages, linguistic issues often led to problems. In an example that Liesbeth Hesselink explores, Malay was the vernacular adopted in Dr. Nel Stokvis-Cohen Stuart's training program for young Javanese women. Yet, subtle communication remained difficult because, as Stokvis-Cohen Stuart noted, "Malay is neither for them nor for us our native tongue." Postcolonial vernacularization often

altered the language of instruction without fully resolving the problem. In the 1950s, with the shift from the Dutch to the American model of medical instruction in newly independent Indonesia, Bahasa Indonesia replaced Dutch as the language in which lectures were given, but textbooks were mainly in English or German, languages that could be difficult for most of the students to follow. Many decolonizing nations in Southeast Asia commenced teaching medicine in their own language, which required sustained efforts by an older generation of physicians to write textbooks and to find vernacular equivalents for Western medical concepts.

Cold War geopolitical realignments brought complicated rearrangements in the goals and languages of medical education and professional communication, as Michitake Aso shows in his examination of the generation of Vietnamese physicians trained between 1950 and 1957 at Hanoi Medical University. Educated in the medical school recently opened by the Vietnamese Communist Party, this generation was the first to receive their education in Vietnamese. Their teachers, however, had been taught in French medical schools, spoke French fluently, and were part of a French international network of physicians.[15] After 1955, medical students primarily spoke Vietnamese, with Chinese and Russian as second languages. The move to Vietnamese was driven by practical reasons such as the fact that after 1945, a diminishing number of medical students spoke French well enough to follow medical instruction in that language. It also sustained the anti-colonial impulse of the Communist government to conduct all aspects of life in oral and written Vietnamese. Medical education provided in Vietnamese not only helped to reinforce Vietnamese independence, but also helped to transform medicine into a prime tool of Communist nation-building. Shifts in language both reflected and were constitutive of the social and political realignments that often informed the replacement of one model of medical education with another, shaping the identity of students and forming their particular sense of community within the cacophony of voices that characterized the professional world of Southeast Asian medicine.[16]

We know from other contexts how crucially important travel and study abroad were in the cross-cultural transmission of medical models. French, Dutch, British, Spanish, and American physicians travelling to Southeast Asia brought with them not only medical techniques and theories but also convictions about how medical education was best accomplished. At the same time, indigenous students and practitioners

who traveled from the colonies to the medical institutions of the imperial metropolis returned not only with medical ideas, techniques, and epistemological convictions, but also with educational and at times political ideals, as did postcolonial medical travelers from newly independent nations who made the journey to the Soviet Union, China, or the United States. Study abroad was often a fundamentally transformative catalyst in the formation of professional identity, an integral ingredient in the ways returning medical migrants hoped to reshape the Southeast Asian medical world. Equally, though, such medical travelers were nearly always extraordinarily selective in what out of everything they had witnessed abroad, they sought to transplant to their native soil and what they deemed better left behind. Good medical models, like medical knowledge, do not simply travel to where they are in short supply: their dissemination or stasis depends upon cultural appraisals made by their potential couriers, whose agency is critical.[17] Vivek Neelakantan shows, for example, that Indonesian medical students who traveled to the United States for postgraduate training in the 1960s reported disappointment with the experience after their return because they found that much of their American medical education was unsuited to the realities of teaching and practice in Indonesia. Transmission was selective, and what medical students and doctors sought to try to transplant to their home countries was not an inevitable consequence of studying abroad, but rather the expression of active choices and purposeful actions that historians need to analyze and explain.

After the turn of the twentieth century, the colonial powers in Southeast Asia became interested in the health of the indigenous population as they started to see themselves as engaging in a civilizing mission instead of merely exploiting their colonies for monetary gain.[18] Western medical care in the colonies had previously only been provided to soldiers, traders, and administrators, the pillars of the colonial administration. Aside from the vaccination campaigns and quarantine regulations, which were designed to protect Westerners resident in the colonies, the indigenous population had been left to look after itself.[19] Often, the only hospitals available for the indigenous populations were established and run by missionaries. Providing medical care to the indigenous population in the colonies fitted the newly adopted civilizing mission of the major colonial powers. Not only would Western medicine demonstrate the superiority of Western science, it would also impart a belief in the benevolence of colonial powers.[20] At the same time, the

economy of most Southeast Asian colonies increasingly shifted from trade to the production of tobacco, rubber, coffee, sugar, and other export staples, on plantations that required a large indigenous labor force. Medicine became an essential element in maintaining and improving this colonial workforce—ideal colonial subjects were healthy and hard-working. After colonies gained independence, the new states of Southeast Asia adopted a very similar stance to medicine and health care as their leaders aspired to develop their economies.

Beyond the pedagogic aim of changing belief and behavior, colonial and most especially postcolonial programs for medical education also encouraged the populace to reconceptualize its own identity in matters of health and health care and to fashion a new sense of health citizenship. A key ingredient in the health education programs conducted by states and by international agencies was to instill in the populace not only a new sense of rights and entitlements in matters of health but also responsibilities and obligations that came with political citizenship. Just as people were encouraged to think differently about their own bodies, their health, and their access to health care, so too they were enjoined to see engagement with educational programs, self-education, and self-transformation in matters of health as a duty. Linking health and citizenship in programs for the medical education of the public implied entitlements, but at the same time imposed the expectation that each individual would be a willing participant in programs for public health and medical change that served such larger ends as economic productivity, modernization, and nationalism. During the Cold War, health and medicine acquired additional political significance as assistance with medical programs became prime bargaining tools used by the great powers to win the hearts and minds of the populations in developing nations. As the contributions to this book begin to show, the global move after World War II to recast medical care as a human right, together with the political and social processes of decolonization, fostered a widespread rethinking about the relationship between health and citizenship in newly independent Asian nations.[21]

Shaping Medical Practitioners

In the historiography of European and American medicine, the education of medical practitioners is at once the most conventional and one of the most densely studied topics. Long the focus of doctors and nurses

intent on tracing their own lineage—often in commemorative histories designed to establish lineage and celebrate progress—since the 1970s it has captured the critical attention of historians and historical sociologists interested in professionalization, the construction of expertise and authority, and the shaping of professional values; of social historians studying midwives, nurses, medical auxiliaries, and the variety of healers who populated the medical marketplace; and scholars in medical history, health policy, medical anthropology, and medical ethics seeking to understand the ethical failings of modern medicine, health disparities, and the shortcomings of modern health care delivery systems. Studies have, in particular, shown how medical education involves not only the acquisition of knowledge but also the formation of professional identity and the training of emotional dispositions.[22]

Like scholars of the history of education more broadly, the contributors to this volume tend to focus on programs of educational reform, precisely because such deliberate efforts to bring about change prompted our historical actors to spell out what otherwise often went unarticulated about what education was designed to do: Who should (and should not) be trained as physicians, nurses, or midwives? How should they be trained? What constitutes a "good" education? What are the larger social, economic, and political purposes that educational programs are designed to serve? What metrics should be enlisted in gauging pedagogic success or failure? And what should the end point—the properly educated practitioner—look like?

The first seven contributions to this volume focus on European- and North American-style medical education in Southeast Asia, ranging from improvised and ad-hoc initiatives in clinics and hospitals to formalized training provided in educational institutions set up by Western powers. Such formal initiatives commenced after the middle of the nineteenth century. In the Philippines, the Spanish colonial administration established the Faculties of Medicine and Pharmacy in 1871 at the University of Santo Tomas. The Philippine Medical School was founded in 1907 by the American colonial government; three years later it was incorporated into the University of the Philippines.[23] In 1851, the colonial administration of the Dutch East Indies opened a school for vaccinators in Batavia; by the turn of the twentieth century, this school had become a full-fledged medical school.[24] The first medical school in French Indochina was established in Hanoi in 1902,[25] while in 1905, the Straits Settlement and Federated Malay States Government Medical School

opened in Singapore.[26] Educational initiatives received a strong inducement around the turn of the twentieth century, after a number of path-breaking demonstrations (such as the role of microorganisms and insect vectors in the transmission of malaria, yellow fever, sleeping sickness, and the plague) provided new perspectives on the diseases that affected colonizer and colonized alike.[27] Colonial public health initiatives in the late nineteenth and early twentieth centuries had been largely limited to enforced, and often resisted, vaccination campaigns and quarantine regulations.[28] However, the new discoveries in parasitology suggested ways in which the prevalence of those diseases that most affected colonial populations could be addressed through preventive measures. It was mostly through the initiatives of the Rockefeller Foundation, starting in the early 1920s, that colonial health officers started to experiment with methods of public health education, thereby repeating similar initiatives that were undertaken in Europe after the bacteriological revolution of the 1870s and 1880s.[29]

Late-colonial and postcolonial Southeast Asia was awash in a sea of models for educating medical practitioners, auxiliary health personnel, and conducting public health education campaigns, models that often coexisted, competed with, and sometimes supplanted one another. At times, certain Southeast Asian countries accepted initiatives from different and often competing Western sources, which underscores the fact that Western medicine was far from monolithic. During the late-colonial period, such models for educational policy, education reform, and medical school curricula more often than not were selectively adapted from the dominant imperial powers. In postcolonial nations, however, and more especially within the context of the Cold War, French, British, American, Soviet, and Chinese models often vied with one another—emulated, transformed, or rejected outright in specific local contexts. At the same time, the World Health Organization (WHO) offered various forms of assistance for expanding medical research and training in developing nations. In the charged atmosphere of the Cold War, such choices had important political ramifications.[30]

Before the turn of the twentieth century, education in Southeast Asia in Western medicine generally relied on apprenticeship and instruction that was provided outside the confines of conventional schools. Some colonial physicians cobbled together their own programs for training auxiliary health workers, as in the instance Hesselink recounts in her chapter on Stokvis-Cohen Stuart's endeavors on Java. From 1908 to 1920, when she lived and practiced medicine in Semarang, Stokvis-

Cohen Stuart, a Dutch-educated pediatrician who was politically well connected, started a training program in nursing and midwifery for young Javanese women because she felt that the initiatives of the colonial government in this area fell short. Working through an outpatient clinic she had set up in the local hospital, her students worked in turns in the hospital and as district nurses in the kampongs, practicing and proselytizing for Western approaches to maternal and neonatal health care. In Stokvis-Cohen Stuart's view, the task to be taken up by European physicians, nurses, and midwives was "not to just keep on doing ourselves but to train, to transmit, to make others competent enough to take over our work."[31] Indeed, the model at the core of her training program was the example set by the European nurses. Pursued at the margins of colonial society by a politically savvy woman physician, this kind of educational model has received scant historical attention precisely because it was conducted outside official channels. Nonetheless, it can be expected that such local and at times ad-hoc initiatives were far more numerous than their formal counterparts.

Nursing education in Southeast Asia was often the stage for international rivalry between different educational models. Rosemary Wall and Anne Marie Rafferty map out the battle lines in the Federated Malay States and the Straits Settlements and reveal how competing educational models were lightning rods for divergent conceptions of what constituted a good nurse in the Malayan context. Both American and British approaches shared a commitment to training local nurses and to the feminization of the local nursing workforce. The British approach emphasized character as one of the most important elements in well-trained nurses and, in particular, in nursing leaders. In the 1920s and 1930s, British nurses stationed in Malaya were training a growing number of Malay, Eurasian, Chinese, and Indian women. Because these Asian nurses were subordinated to those from Britain, local nurses were not able to fully use their skills and management experience, even at times when hospitals were short of nurses, resulting, in the 1950s and the coming of independence, in a staffing crisis.

In contrast, the American model, for which the Rockefeller Foundation proselytized during the same decades, downplayed matters of character and social status, and instead favored a techno-scientific approach, emphasizing the importance of developing leadership among locally trained Asian nurses. Malaya had been one of the Rockefeller Foundation International Health Commission's first areas for attention in 1913–15, and during the 1920s it was the Rockefeller Foundation, rather

than the British, that took the initiative in training public health nurses. The Rockefeller Foundation sought to further promote the American style of nursing education by arranging for British nurses in Malaya to receive advanced training in public health nursing in the United States, a plan that met with limited success. Wall and Rafferty further underscore the contrast between British and American models by pointing to the Americanization of nursing in the Philippines, which from early in the century encouraged the promotion of locally-trained Asian nurses, prioritizing capacity-building and training nursing leaders. The colonial philosophy emphasizing Britishness and character in nursing in Malaya, they conclude, was not as well calculated as the American model to produce an enduring nursing legacy, and after independence from Britain, resulted in a call for help by Malaysia to the World Health Organization (WHO) to assist in building postcolonial nursing leadership.

Debates about the organization of medical education and the indigenization of the health care workforce locally trained in Western medicine were not limited to initiatives in caring for human beings. As Annick Guénel shows, French veterinarians trained Indochinese auxiliary-veterinarians to teach local farmers about hygiene, rational breeding methods, treatment, and animal health. Owing to their knowledge of local language and customs, a French veterinarian commented in 1923, "the auxiliary-veterinarians are the best suited intermediaries" between the "imported scientific methods" of the French veterinarians and the "ignorant" colonized peasants, "and therefore have to play a highly important role as educators. Better enlightened by them, the local farmer will apply all requirements relating to hygiene, treatment, and animal health."[32] Like indigenous nurses and midwives, these veterinary students were educated to practice medicine, but were primarily functioning as go-betweens, intermediaries, or cultural brokers in the wider hygienic education of the populace. These intermediaries translated into indigenous languages and vernacular practices Western ideas and techniques pertaining to animal bodies and the diseases that could potentially limit their productivity with the aim of improving animal health. When these intermediaries were successful, they provided a link between the Western world of science and medicine and indigenous practices. Yet, like locally trained physicians who were often considered auxiliaries positioned below their European counterparts, intermediaries occupied ambiguous and paradoxical positions, as frequently they were not respected as full colleagues by Western physicians and were sometimes regarded as outlandish by the indigenous population.

Embedded in all of the educational models discussed in this volume are assumptions about what kind of individuals were best suited to be recruited as students. This question loomed large for those who spearheaded educational initiatives, shaped policy, and designed programs for reform. Key to Stokvis-Cohen Stuart's plan, for example, was drawing her student nurses from the Javanese elite, in particular young women of noble birth who had already received some education. Hesselink shows how their social status, class, and potential as role models for the general population were essential ingredients in Stokvis-Cohen Stuart's overarching aspiration to see her graduates compete successfully with the greatly respected *dukun bayi*, the traditional birth attendant. In many ways, the education of the former in modern medical methods had to compete with the age, experience, and established social position of the latter. In colonial Malaya, ethnicity and religion also figured prominently in nursing programs in much the same way that class did in the Dutch East Indies. As Wall and Rafferty show, British nursing educators persistently tried to recruit Malay women as students, in part because of the challenges they encountered in trying to impose Western structures on a largely Muslim country. However, often they were frustrated by the extent to which they had to resort instead to Eurasian applicants. The case of British Malaya stands in sharp contrast to that of the Philippines, where from the early decades of the American occupation nursing educators successfully promoted the training of nurses from the local population.[33] As Kathryn Sweet notes in her chapter on maternal and child health, the situation in French colonial Laos resembled conditions in Malaya rather than those in the Philippines, as recruiting Lao women to nursing and midwifery training programs was a persistent aim and repeated failure. Throughout the colonial period, nearly all hospital staff in Laos were Vietnamese men. Colonial physicians were acutely aware of the difficulties involved in attracting Lao patients to French medical services. They hoped that increasing the number of Lao nurses and midwives would help attract Lao patients, especially women, and in the 1920s deliberately set out to recruit Lao students. This proved difficult, though, not least of all because of the expectation of a primary education and basic literacy in French language.

After Southeast Asian colonies gained independence, they aimed to reconfigure medical education to suit the needs of their newly independent nations. Neelakantan shows how in Indonesia during the 1950s, leading medical educators sought to replace the Dutch colonial model for training physicians with an American model at the two leading

medical schools in Jakarta and Surabaya. Indonesia had inherited the Dutch academic approach to medical education, which in turn was patterned after the German model, an academic approach that emphasized individual "free" study, which allowed students to take their examinations whenever they felt adequately prepared and to sit multiple times for their examination. This approach to medical education emphasized engagement with research and graduated a small number of highly qualified researchers; at the same time, it had astronomical attrition rates. Medical education in the Dutch East Indies had been organized this way since 1927. After 1950, the Faculty of Medicine at the University of Indonesia, which still followed this model, graduated about two dozen highly qualified physicians a year. The model consequently failed to address the acute shortage of physicians in Indonesia, which had, in 1950, about 1,200 physicians for a population of 70 million. Nor did it provide sufficient medical personnel to address pressing public health problems, such as maternal mortality, infant malnutrition, nutritional disorders, resurgent epidemic diseases such as smallpox and cholera, and endemic diseases like malaria and yaws. Starting in 1952, proposals were made to address these problems by remodeling the medical curriculum on the American model, in which classes of medical students moved as a cohort stepwise through the educational program, taking both classes and exams together. To help implement this reform, the medical schools of the University of Indonesia in Jakarta (in 1955) and of Airlangga University in Surabaya (in 1959) affiliated themselves with the University of California's school of medicine in San Francisco.

The attempt to supplant one educational model with another one in the instance of Indonesia was in part an international aid initiative, with funding provided by the Technical Cooperation administration of the United States government and the China Medical Board in New York.[34] For these American funding agencies, the shift from a Dutch to an American model was part of a larger Cold War project to win the confidence and loyalty of emerging nation states. Yet, as in other decolonized Southeast Asian countries, Indonesian politicians were suspicious of such international aid initiatives because they potentially constituted infringements on Indonesia's hard-won political sovereignty. They were wary that the educational alliance between two Indonesian and one American medical schools would enable the United States to exert undue influence on Indonesian politics. The remodeling of medical training at Jakarta's University of Indonesia succeeded, but in 1969 the medical school in Surabaya reverted to the Dutch model. The American version

had not turned out to be as successful as its promoters had hoped, in part because of a shortage of qualified instructors, lack of equipment for laboratory classes, and language problems. While medical educators endorsed the ideals of the American model of medical education, they did not have the resources to implement it.

After independence, the new nations in Southeast Asia were able to pick and choose from a whole host of educational models that were available on the international medical market, choices that were shaped and constrained by local health care priorities as well as Cold War geopolitics. In Cambodia, for example, Soviet mentorship and medical aid was part of a larger effort to counter the influence of the United States and Western Europe, and it was in this context during the 1960s that the Soviet Union became the first country to rival the French in setting the model for Cambodian medicine. As Jenna Grant shows, the Soviet Union supplanted colonial French approaches to medical education. Cambodian Prince Sihanouk embraced the Soviet model prioritizing high-tech urban hospitals for state-of-the-art training, care, and knowledge dissemination and cast Soviet-style biomedicine as an instrument of decolonization. The bricks-and-mortar embodiment of this model was the Khmer-Soviet Friendship Hospital, which was built in 1960 in Phnom Penh with funds from the Soviet Union and was, at the time, the largest hospital in Southeast Asia. At this hospital, physicians provided medical training programs and published a Khmer-Soviet medical journal, which clearly expressed Khmer aspirations to a particular kind of cosmopolitan modernity that embraced an ideal of high-tech, hospital-based biomedicine. Equally revealing, though, are the models for medical education that Cambodia rejected. In 1965, for example, Cambodian leaders refused China's offer to build an institute for training barefoot doctors, a distinct counterpoint to the Soviet biomedical model that would have charted a very different path for Cambodia's postcolonial medical education and national identity.[35]

Public Health Education and the Fashioning of Health Citizenship

Imposition and the use of force rather than persuasion and education characterized most public health campaigns in colonial Southeast Asia before the turn of the twentieth century. Medical and public health interventions alike were often authoritarian—a matter of domination rather than hegemony—exercising the kind of police powers that since the

eighteenth century had grown common in the European imperial states.[36] Compulsory vaccination, mandatory quarantines, and the intrusions of the public health apparatus into private spaces and intimate routines exemplified the involuntary nature of much of colonial health care provision, in which compliance was compelled rather than belief remolded or demand created. The use of force was often justified by referring to the low level of development of the indigenous population and the "primitive" beliefs to which they adhered. Colonial administrators were convinced that it was not worth their while trying to convince colonial subjects of the benevolent nature of medical interventions.

Yet, the prominence of teaching in the daily medical practice of doctors, nurses, and midwives in Southeast Asia—particularly in the labors of local, indigenous health care workers—calls attention to the extent to which even in the colonial period, the aim often was not merely to impose, but to persuade. In the lived world of workaday interactions, health care workers educated in Western medicine often found themselves wedged in an ambiguous position between Western physicians and indigenous populations. They also found themselves in competition with a whole host of other indigenous practitioners who relied on healing knowledge that was part and parcel of indigenous epistemologies and held its own social, cultural, and political meanings.[37] They were promoting health products and ideas, practices and practitioners, in pluralistic medical marketplaces. Essential to inculcating new ideas about health and illness was fitting into indigenous society and existing social roles. At times this meant cooperating with traditional healers, incorporating indigenous healing practices, and recasting Western precepts into local frameworks, yet all the while with an aspiration to instill a new medical cosmology. The educational task at hand was not merely to exhort the populace to take up particular health behaviors, but more fundamentally to persuade them to embrace new interpretations, explanations, and expectations—that is, to *convert* them to a new medical belief system.

Sites such as outpatient clinics, hospitals, and infant welfare centers, in addition to providing health care, also functioned as educational institutions. There were also organized initiatives explicitly devoted to promoting Western medical ideas to indigenous populations, such as the Division of Medical-Hygienic Propaganda that the Dutch East Indies Department of Public Health set up in 1925 with funding provided by the Rockefeller Foundation.[38] The most expansively staged and intensively organized educational initiatives were public health campaigns.

Such educational programs were based on the premise that making colonial empires healthy could only be achieved by modifying individual hygiene habits and the conduct of domestic and civic life, which in turn depended on a populace that heeded the lessons of the new public health developed around the turn of the twentieth century in Europe and North America. Educational projects launched by the Rockefeller Foundation, preaching the "gospel of germs," included demonstration projects on how to combat sleeping sickness, the erection of sanitary privies, and the use of movies and slide shows to make the indigenous population familiar with parasites and methods of disease transmission.[39] In the 1920s and 1930s, this educational impulse was vividly displayed by the Rockefeller Foundation's anti-hookworm campaigns, which in places like British Malaya and the American-occupied Philippines, just as in Latin America and the southern United States, carefully sought to cast its lessons about pathology, prevention, and cure in cultural forms that would resonate with the particular population they hoped to reach.[40] Yet, at other times, indigenous physicians embraced activities such as hygienic reform and public health education as forms of protest against the occupying powers and as activities that supported the building of independent societies.[41]

Health initiatives and education programs often failed, sometimes stymied by resentment and resistance to colonial power. As Francis A. Gealogo shows, for example, American colonial authorities in the Philippines viewed the 1918 influenza pandemic as a sterling opportunity to mount a public health education campaign that would not only help check the spread of the disease but also catalyze a more lasting change in Filipino hygienic belief and behavior. Yet, instead of being welcomed as signs of American biomedical expertise and benevolence, the colonial government's health education campaigns were widely regarded as one of the main causes of the suffering of the people. Drawing on popular literature that circulated at the height of the epidemic, Gealogo traces the propagation of alternative interpretations of the influenza epidemic, which related its severity to the poverty of the indigenous population. Filipinos revived the satirical prayers that had been popular during earlier cholera epidemics and transformed them into petitions for deliverance equally from disease and from abusive American oppression. American hygienic instruction had limited purchase in a political context in which most Filipinos held the American colonial occupation and its instruments, including biomedicine, responsible for Filipino suffering.

Medical go-betweens were one vehicle for conveying health lessons to the populace, but there were others, and the chapters in this volume provide glimpses into the sheer variety of media that were enlisted in educational programs. Laurence Monnais, for example, points to how, in French Indochina during the interwar decades, the *Assistance Médicale Indigène* used elementary schools, public conferences, and pamphlets to teach children and adults about hygiene. Guénel, in her exploration of animal health during the same period, calls attention to how leaflets in local languages were distributed to village heads, how school farms supplemented the practical education they conveyed to young Cambodians through courses and films, and how French veterinarians used fairs, agricultural shows, and lectures as vehicles for reaching Indochinese peasants. And Grant notes how, in postcolonial Cambodia, newsreels and films were used to hold up a particular vision of high-tech biomedicine as a model for national aspirations. Local manufacturers of alternative medicines often used newspapers for publishing advertisements and disseminating health information.[42] In the West, where modern medicine and the modern mass media co-developed from the late-nineteenth century into two of the most successful industries of the twentieth century, advertising, newspapers, magazines, exhibitions, radio, film, television, and later the Internet all played critical roles in the communication of health information to the public as well as in forming expectations of medical power and health citizenship. The tantalizing hints in these chapters about the place the media occupied in the wider health education of the Southeast Asian populace suggest the promise of further exploration—as in Gealogo's account of the leaflets and flyers on influenza control that the Bureau of Public Health circulated to Filipino school children, shop-workers, laborers, and householders, and in Monnais' close analysis of the Vietnamese popular press and a health magazine published by a private French pharmacy as a platform for advertising in the 1920s and 1930s, and the role they played in disseminating knowledge about health, prevention, and self-care.

Indeed, Monnais' analysis of the dynamic medical marketplace in which these media circulated enables her to discern important and widely generalizable patterns of popular health care demand and colonial patient agency. The promotion of Western medical practices often met with a recalcitrant populace, something Monnais demonstrates with the examples of Indochinese rejection of vaccines and refusal of quinine. Sometime around World War I, however, there was an intriguing shift among

the Vietnamese from rejecting Western medicines to wholeheartedly embracing some Western cures. Looking closely at drug advertisements, packaging, the marketing of medications through newspapers, and at pharmacies themselves, along with the ways that remedies were assimilated into existing local cultural configurations, Monnais reveals the selective process through which some pharmaceuticals were enthusiastically taken up. Demand for certain Western therapies, combined with enduring popular insistence on medical pluralism, in turn encouraged some traditional Sino-Vietnamese practitioners to appropriate biomedical treatments in order to meet their clients' demands. By the late 1930s, instead of simply condemning popular rejection of colonial medicines, some colonial doctors seemed ready to accept therapeutic pluralism as a necessary platform for achieving their wider educational and professional aims.[43] Understanding this "education from below," Monnais concludes, not only underscores the active agency of colonial subjects in the process of medicalization, but also reveals an early form "therapeutic citizenship" in a colonial context.

After World War II, public health education campaigns intensified, and language about civilizing missions gave way to a growing discourse on development. The medical ideas that, during colonial times, had been imported by Western physicians and had often been imposed on indigenous populations were now advocated by indigenous physicians and public health administrators. The international agencies that took an interest in public health education increased sharply, often representing public health as a depoliticized field but—for prospective funders in Western Europe and the United States—simultaneously responding to the fear that poor health was a breeding ground for communism. Organizations like the WHO funded programs of public health nursing in Malaya and rural midwifery in Laos, forms of technical assistance with a strong educational component.

The Invention of "Traditional Medicine"

While highlighting the plethora of Western models for medical education in Southeast Asia, the essays in this book also point to the deliberate creation of explicitly Asian counter-models. From the colonial era to the present, the graduates of medical schools patterned after Western models to teach Western medicine coexisted and competed with indigenous healers, sometimes trained in formally organized schools but most

often by apprenticeship to practicing healers. However, with the intensification of nationalism and broader cultural revivalist movements, such as Ayurveda-Unani Tibb in India, Traditional Chinese Medicine in China, and Kampo in Japan, the politics of medical indigeneity also informed the rise of new kinds of systematic, institutionalized, and increasingly commodified training programs in what came to be styled as "traditional" forms of Southeast Asian medicine.[44] Organized training programs in explicitly alternative forms of medicine and the establishment of organizations of practitioners mirrored the ways in which Western physicians had set up medical education and the medical profession. In Southeast Asia, such programs and associations were set up in response to the incursions of Western medicine.

Junko Iida offers a lucid analysis of the construction of "traditional" Thai medicine and Thai massage at the end of the nineteenth century. Conventional Thai medical knowledge and practice came to be called "traditional" only after Western medicine was introduced in a hospital setting after 1887, and became increasingly marginalized after the Westernization of medical education intensified with support of the Rockefeller Foundation in 1922 and as people came more and more to accept Western medical ways.[45] The collection of texts regarded as canonical today were compiled only in the 1870s, while the first textbooks in Thai traditional medicine were assembled only early in the twentieth century.[46] Buddhist temples started to provide instruction in "traditional" medicine and a number of leading graduates established traditional medical organizations. In the face of anxieties about communism in the 1950s, practitioners of Thai medicine integrated their allegiance to the monarchy and their Buddhist beliefs by forging a link between, on the one hand, teaching, learning, and practicing traditional medicine and, on the other hand, a larger national revivalist project.[47] They established institutions like the School and Association of Traditional Medicine in Thailand in 1957 at Wat Pho in Bangkok and the Old Medical Hospital School in Chiang Mai in the 1960s (which C. Pierce Salguero explores in his chapter). These institutions emerged as prominent centers for educating practitioners of traditional Thai medicine. When in 1978 the WHO started to promote indigenous medicine as part of its global primary health care initiative, Traditional Thai Medicine (TTM) began to gain support from the Thai government, which took an increasingly active role not only in its promotion and standardization but also in the regulation of its training, curriculum, and

licensing standards.[48] The government move to institutional TTM in the 1990s established a formalized model for training not only "traditional" practitioners, but also for training biomedical professionals in TTM and providing the expanding tourist industry with commercialized courses.

The creation, perpetuation, and meaning of collective identity is a theme that pervades the contributions to this book, explored in contexts ranging from professional associations of colonial nurses and midwives in Indonesia, Malaysia, and the Philippines, to the imagined community of biomedical physicians in postcolonial Cambodia, to the transitional generation of biomedical doctors medically trained for the first time in Vietnamese in ways that allied them as a group with the political goals of the Viet Minh. It is especially clear in Salguero's analysis of an elaborate version of the annual ceremony for "paying respect to the teachers" celebrated in 2012 at a TTM school in Chiang Mai. Both Iida and Salguero describe the periodic *wai khru* ritual performed by TTM practitioners to honor both their living teachers and the extended lineage of predecessors from whom they have acquired their knowledge and identity, a rite deemed essential to their success as healers. Salguero goes on to show how the ceremony not only links students and staff at the medical school to their mentors and spiritual guides, but also constructs and maintains a sense of tradition and lineage. More than this, it serves to unite a community of practitioners—students, graduates, and a wider network of TTM schools in the region. Here as elsewhere, medical education binds students together in a common lineage, establishing their claim to shared beliefs, practices, and values that defines collective identity, confers a sense of social and cultural belonging, and provides a guiding framework for conduct in the world.

The Multiple Meanings of Medical Education

While educational models, policy, and programs for reform continue to garner the lion's share of attention in the historiography of medical education, the contributions to this book begin to offer insight into some of the workaday realities of educational practice, including the material culture of pedagogy—classrooms, equipment, laboratories, and bodies. More often than not these drew comments from policy-makers and reformers only when they were targets for change, while the routine, the undisputed, and the stable passed as quite literally unremarkable. But there are particularly intriguing references in the chapters that

invite close historical investigation. For example, Hesselink notes that in Stokvis-Cohen Stuart's training program for Javanese nurses in the 1910s, the pupils not only were taught anatomy two to three times a week by a *dokter djawa* but also attended autopsies. Western medicine relied fundamentally on experiential learning through the bodies of teaching subjects, living and dead, and access was often a function of class, race, and ethnicity. And pedagogic access to bodies has often been shown to be a particularly revealing site for identifying differing national sensibilities in medical education and for getting at fundamental issues of ethics.[49] That these Javanese nursing students were able to learn not only by examining the bodies of the sick in the outpatient clinic but also from witnessing dissected bodies at autopsy raises all sorts of questions for further investigation: In Indonesia and elsewhere, for example, where did the bodies come from? Whose bodies were they? Was there a shift in colonial to postcolonial access to human teaching material?

Physician, nurse, and midwife were far from stable categories in Southeast Asia, varying over time and place, and the essays in this collection begin to reveal the multiplicity of envisioned products of various educational models, as well as the larger medical, social, and political work particular educational initiatives were designed to serve. The medically educated graduate was almost always expected to practice as a health care worker, and sometimes as a medical researcher or public health official. Yet, that seldom exhausted the larger work these practitioners were expected to perform in the world—what they were to do, and to be. Accordingly, the contributors to this volume pose the questions: Education for what? What were the students being trained to become? What precisely was their work expected to accomplish? Which social spaces in colonial or postcolonial society were these graduates supposed to occupy? Sometimes the task of the envisioned graduate was quite specific. The Vietnamese doctors Aso examines who started their training in 1950, at the height of the military conflict with France, and who, as students, regularly traveled to the war front to treat the wounded, were educated almost exclusively to meet immediate military needs. In Indonesia during the same decade, the shift from a Dutch to American model was partly designed to replace the education of students to be medical researchers with an orientation towards producing practitioners of medicine and public health. Whereas in Cambodia in the 1960s and Indonesia late in the century, the ideal doctor portrayed in

a medium, such as the Khmer-Soviet medical journal Grant examines, was to be an embodiment of biomedical expertise and exemplar of modernity. What counted as a good doctor in one context was not necessarily the same in other contexts.

The most persistent role beyond healer envisioned for the graduates of late-colonial and early-postcolonial Southeast Asian educational programs, though, was that of teacher. And such medical teachers of the public prominently populate nearly all of the contributions to this book. Within the framework of a "civilizing mission"—the Ethical Policy of the Dutch, "white man's burden" of the English, and "mission civilisatrice" of the French—the leading ills they were being educated to cure were those one Dutch East Indies medical educator described as "public prejudice rooted in superstition, ignorance, and customs,"[50] pathologies in which hygienic, aesthetic, and moral symptoms were often intertwined. To this extent, they were being trained to be on-the-ground agents of what might later be described as "hygienic modernity."[51] Through their daily work, medical practitioners functioned as cultural conduits for infusing Western medical ways into the larger society.

This was especially the case with the education of indigenous nurses and midwives of the sort Stokvis-Cohen Stuart trained not only to provide health care, but also to be vehicles for educating the population—to, in her words, "open their eyes to Western ideas about hygiene." At the heart of her program for introducing Western medical convictions and hygienic practices into the kampong was winning over Javanese women through the culture-savvy efforts of women medical practitioner-teachers. As she put it succinctly, "In my view, we can only improve hygiene and sick-care if we reach the women, and the Javanese woman is not easy to reach. Her trust is easiest gained through women, [for] they understand the psyche of the patients much better, and surmount the difficulties much more easily."[52] Pointing to a pattern discernible across Southeast Asia, Hesselink shows how gender, ethnicity, social status, and sometimes even age were as important as any formal training or certification in enabling these nurses and midwives to fit into indigenous society and existing social roles, providing a platform for teaching that was less available to European medical practitioners. They were to be what Stokvis-Cohen Stuart tellingly called "go-betweens."[53] What is especially revealing is how she insisted that even if her graduates married and left the profession, it was no loss to her larger mission, because they would continue to spread the

knowledge they had gained about hygiene and nursing to other Javanese women in their community. So too with other kinds of auxiliary medical workers and the indigenization of the health care force locally trained in Western medicine.

One interest that all the contributions to this book share is the way in which they demonstrate in specific local contexts how education is a political act. Exemplified, not least of all, by the ways that Western medical knowledge was promoted in Southeast Asia, both medical and ideological criteria took part in determining what—out of all the available kinds of medical knowledge—was included in the curricula of schools and what was left out, reinforcing prevailing patterns of dominance and subordination.[54] What counts as authoritative medical knowledge, where and how is it best transmitted, and who gets to make these decisions? At the same time, the aims that medical education was designed to serve in particular times and places often embodied quintessentially political commitments and aspirations, evident equally in the colonial project and in programs of decolonization, modernization, international diplomacy, and nation-building. In many ways, physicians of the newly decolonized nations of Southeast Asia transformed medicine from a tool of empire into an instrument of nation-building. Continuities over time in medical initiatives acquired new meanings through discontinuities in political organization.

The overt instrumental aim of keeping people healthy and restoring the ill to health had its own political purposes, which also changed over time. During the colonial period, the shift from guarding the health of civil servants and soldiers to a wider civilizing mission was often bound up with the premise that a healthy populace was important to an economically productive colony. Training medical doctors could also contribute to anti-colonial projects, as Aso notes of the way in which medicine helped the Viet Minh gain legitimacy among the people in their fight against the French. Still later, for the new nations of the region, health and disease—especially epidemics—were one indicator of governmental success or failure, an index of economic well-being and of the state's ability to care for its citizens.[55] The medical education of doctors, nurses, midwives, and citizens alike aimed at reducing the burden of illness on the population while simultaneously guarding the health of the body politic. Modernization was the most pervasive framework for delineating the larger meaning of medical education to postcolonial Southeast Asian societies. Teaching biomedicine to health care

professionals and inculcating hygienic modernity in the populace both served the aim of creating new epistemological communities defined most fundamentally by shared trust in the authority and promise of techno-scientific expertise.

Education for health could also be a form of international diplomacy, intensifying during the Cold War as international agencies engaged with medicine proliferated, sponsoring myriad development aid projects. And yet, shifting development priorities and tunnel vision could also work at cross purposes with the power of education to bring about durable change. Sweet, for example, taking the case of Laos, inserts the important caveat that sometimes the complex patchwork of overlapping programs, and the ruptures that came with changes in regime, health policy, or the donors providing international development assistance, were a source of remarkable unsustainability. Focusing on maternal health care, midwifery, and family planning, she finds that among the explanations for poor health outcomes is the repeated failure of the Lao government and international development agencies to critically examine the achievements and shortcomings of previous approaches to women's health. In this instance, she shows, an ahistorical approach to medical education has taken a toll on Lao women's health, underscoring the importance of educating the developers about history.

In the context of postcolonial and Cold War geopolitics, medical education also figured in nation-building. What is particularly intriguing is the strikingly divergent pathways this process could follow, reflecting what, at first glance, might seem like contradictory cultural choices. Grant, for example, by exploring how biomedicine was held up as an emblem of Cambodian nation-building in the 1960s, demonstrates how such medical practices as constructing high-tech hospitals, training professionals, and publishing medical texts all played a role in crafting a very specific model for national medical identity. The first Cambodian medical journal, published between 1961 and 1971 by the Khmer-Soviet Friendship Hospital, itself a vehicle of education, held up a particular model of biomedical rigor and excellence for emulation. For most Cambodian doctors, this Soviet model was an ideal to be aspired to, not a reachable goal, but it invited them to share in a collective national identity that would serve both modernization and nation-building. Tellingly, indigenous medical traditions, robustly cultivated in the community, were all but invisible in the journal's pages, marginalized in the modernist vision of the new Cambodian nation.

In stark contrast is the cultivation of indigenous medical tradition that Iida portrays as part of Thai nation-building. In Thailand, too, indigenous medicine—which began to be called "traditional medicine" only in the late nineteenth century—was marginalized as acceptance of Western medicine increased. Early in the twentieth century, the first publications on "traditional medicine" were compiled as part of the monarch's larger project of reviving the political, social, and cultural aspects of Thai tradition. But it was in the 1950s, when the Thai government was challenged by communism, that the revivalist project intensified. It was within this context, as Iida shows, that the teaching and practice of TTM emerged, celebrated as a distinctively Thai counterpoint to biomedicine. Standardization and institutionalization during the ensuing decades sometimes was modeled after biomedicine, but the TTM revivalist movement remained rooted in a nation-state ideology promoting a Thai national identity.

Medical education, like education in general, is meant to be transformative, intended to provide not only new knowledge and technical skills but also new values, responsibilities, and obligations. One pervasive aim shared by medical educators is to confer a new identity—sometimes tied to larger projects for remolding regional and national identities such as modernization, decolonization, and nation-building. Interwoven in the contributions to this book are fundamental questions about the relationship between medical education and the shaping of individual and collective identities, both those implicated in health citizenship and others fostered by training programs for medical practitioners. Translating the body went hand in hand with fashioning identity. How, for example, did graduates of medical, nursing, or midwifery programs come to see themselves, individually and collectively? How did they conceptualize their place vis-à-vis other healers, their medical, social, and cultural role, and their competitive niche in the medical marketplace? To what extent did they derive their identity and authority from what they were not? So too, how were the practitioners who acquired their identities from various educational plans seen by prospective patients? When did people turn to a biomedically-trained doctor, and when to an indigenous healer? How were their choices informed by programs of medical education aimed at fashioning health citizenship? And how was that education enacted in everyday practice? Medical education initiated students into particular traditions of ideas, practices, and values. How did they display that shared transformative experience

once they were out in practice—in, for example, networks or associations among those whose education had conferred the claim to a common lineage?

Taken together, the chapters in this collection, beyond beginning to map out the history of medical education in Southeast Asia, seek to suggest how medical education offers Southeast Asianists a historiographically strategic framework for understanding health and medicine in the region and for getting at wider questions about social, cultural, and political change and choice. A historicized understanding of medical education, we contend, also represents an important resource for guiding health policy and development work in the present. Finally, this collection seeks to help integrate Southeast Asia into a wider understanding of medicine and societies by historians who are not experts in the region but who are working to shape a vision of what a global history of medicine can and should look like and what difference it stands to make to the local studies we all pursue. Ideas of health, disease, and the body went hand in hand with shaping individual identities and building modern nations. Translating the body was, and continues to be, part and parcel of the formation of the global world.

To Southeast Asianists, many of whom might consider history of medicine to be an arcane sub-discipline, the contributions to this volume argue for the larger historiographic promise of exploring how modern understandings of the body have been shaped, as well as the ways in which medicine, health, and health care offer a platform for analyzing larger social, political, economic, and cultural issues. To historians of medicine, whose collective focus until recently tended to be on other parts of the world, the exploration of medical education in Southeast Asia not only suggestively enriches our understanding of European and American contexts but also makes a formidable contribution to the ongoing process of globalizing the history of medicine. To historians interested in the genealogy of the global world, the case studies presented in this book illustrate how international medical initiatives created networks that were among the first connecting different parts of the world together, providing precursors to the appearance of the global world.[56] Together, the essays in this collection constitute a call for Southeast Asianists, historians of the global world, and historians of medicine, health, and health care to consider what the history of medical education in Southeast Asia is and should be, and the wider interpretive work it can do.

Notes

1. Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton: Princeton University Press, 1999), 5–6.
2. Vicente L. Rafael, "Betraying Empire: Translation and the Ideology of Conquest," *Translation Studies* 8, no. 1 (2015): 82–93; and see also Rafael's "The War of Translation: Colonial Education, American English, and Tagalog Slang in the Philippines," *Journal of Asian Studies* 74, no. 2 (2015): 283–302, and *Motherless Tongues: The Insurgency of Language amid Wars of Translation* (Durham, NC: Duke University Press, 2016).
3. This applies not only to the translation of European medical insights into Southeast Asian vernaculars, but also to the transmission of medical knowledge between cultural domains in general. See, for example, C. Pierce Salguero, *Translating Buddhist Medicine in Medieval China* (Philadelphia: University of Pennsylvania Press, 2014).
4. Sanford Budick, "Crises of Alterity: Cultural Untranslatability and the Experience of Secondary Otherness," in Sanford Budick and Wolfgang Iser, *The Translatability of Cultures: Figurations of the Space Between* (Stanford: Stanford University Press, 1996), 1–22, quote on 11. Eclectic but helpful starting points into the massive literature on translation theory have been Eric Cheyfitz, *The Poetics of Imperialism: Translation and Colonization from* The Tempest *to* Tarzan (New York: Oxford University Press, 1991); Lydia H. Liu, *Translingual Practice: Literature, National Culture, and Translated Modernity—China, 1900–1937* (Stanford: Stanford University Press, 1995); Saliha Paker, *Translations: (Re)Shaping of Literature and Culture* (Istanbul: Boğaziçi University Press, 2002); Hortensia Pârlog, Pia Brînzeu, and Aba-Carina Pârlog, *Translating the Body* (Munich: Lincom Europa, 2007); and especially George Steiner, *After Babel: Aspects of Language and Translation*, 3rd ed. (Oxford: Oxford University Press, 1998).
5. Particularly helpful here is Michael D. Gordin, *Scientific Babel: How Science Was Done Before and After Global English* (Chicago and London: University of Chicago Press, 2015). The kind of cultural translation at work in medical education should be distinguished in both agency and intent from "the translation of cultures" that since the 1950s has been held up as the distinctive task of social anthropology; see Talal Asad, "The Concept of Cultural Translation in British Social Anthropology," in *Writing Culture: The Poetics and Politics of Ethnography*, ed. James D. Clifford and George E. Marcus (Berkeley, Los Angeles, and London: University of California Press, 1986), 141–64.
6. A helpful historical exploration of the relationship between health and citizenship in the West is Harry Oosterhuis and Frank Huisman, "The Politics of Health and Citizenship: Historical and Contemporary Perspectives," in

Health and Citizenship: Political Cultures of Health in Modern Europe, ed. Huisman and Oosterhuis (London: Pickering and Chatto, 2014), 1–40.

7. George Basalla, "The Spread of Western Science," *Science* 156, no. 3775 (1967): 611–22.
8. David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993); David Arnold, ed., *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500–1900* (Amsterdam: Rodopi, 1996); Andrew Cunningham and Bridie Andrews, eds, *Western Medicine as Contested Knowledge* (Manchester: Manchester University Press, 1997); Mary P. Sutphen and Bridie Andrews, eds, *Medicine and Colonial Identity* (London: Routledge, 2003); Norman G. Owen, ed., *Death and Disease in Southeast Asia: Explorations in Social Medicine and Demographic History* (Singapore: Oxford University Press, 1987); Ming-Cheng Lo, *Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan* (Berkeley: University of California Press, 2002); Steven Palmer, *Launching Global Health: The Caribbean Odyssey of the Rockefeller Foundation* (Ann Arbor: University of Michigan Press, 2010).
9. John R. Pierce, *Yellow Jack: How Yellow Fever Ravaged America and Walter Reed Discovered Its Deadly Secrets* (Hoboken, NJ: Wiley, 2005). For a recent and strong historiographic counterpoint, see Mariola Espinosa, *Epidemic Invasions: Yellow Fever and the Limits of Cuban Independence, 1878–1930* (Chicago: University of Chicago Press, 2009).
10. Ronald Ross Archives, London School of Hygiene and Tropical Medicine, "Letter to William C. Gorgas, March 23, 1914," quoted in R. Patterson, "Dr. William Gorgas and his War with the Mosquito," *Canadian Medical Association Journal* 141, no. 6 (1989): 599.
11. Roy MacLeod and Milton Lewis, "Preface," in *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, ed. Roy MacLeod and Milton Lewis (London: Routledge, 1988), x.
12. Arnold, *Colonizing the Body*; Cristiana Bastos, "Teaching European Medicine in 19th Century Goa: Local and Colonial Agendas," in *Contesting Colonial Authority: Medicine and Indigenous Responses in Nineteenth- and Twentieth-century India*, ed. Poonam Bala (New York: Lexington Books, 2012); Marcos Cueto and Steven Palmer, *Medicine and Public Health in Latin America: A History* (New York: Cambridge University Press, 2015); Annick Guénel, "La lutte antivariolique en Extrême-Orient: Ruptures et continuité," in *L'Aventure de la Vaccination*, ed. Anne-Marie Moulin (Geneva: Fayard, 1996); Ann Janetta, *The Vaccinators: Smallpox, Medical Knowledge, and the Opening of Japan* (Stanford: Stanford University Press, 2007); C. Michele Thompson, *Vietnamese Traditional Medicine: A Social History* (Singapore: NUS Press, 2015); Megan Vaughan, *Curing*

Their Ills: Colonial Power and African Illness (Stanford, CA: Stanford University Press, 1991).

13. Laurence Monnais and David Wright, eds, *Doctors beyond Borders: The Transnational Migration of Physicians in the Twentieth Century* (Toronto: University of Toronto Press, 2016).
14. The well-studied East Asian case of hyper-colonized Taiwan—with German, Japanese, Chinese, and English all at play in the medical world—is suggestive here; see in particular Lo, *Doctors within Borders*.
15. Laurence Monnais-Rousselot, *Médecine et colonisation: L'aventure indochinoise, 1860–1939* (Paris: CNRS Editions, 1999). For a historically-grounded discussion of language and linguistic policy in education as an exercise of colonial power, see Johannes Fabian, *Language and Colonial Power: The Appropriation of Swahili in the Former Belgian Congo, 1880–1938* (Cambridge: Cambridge University Press, 1986); and see Prakash, "Translation and Power," in *Another Reason*, 49–85.
16. On the relationship of physicians to nationalist movements and the process of decolonization, see Warwick Anderson and Hans Pols, "Scientific Patriotism: Medical Science and National Self-Fashioning in Southeast Asia," *Comparative Studies in Society and History* 54, no. 1 (2012): 93–113, and Lo, *Doctors within Borders*.
17. See, for example, Hsiu-Jane Chen, *"Eine strenge Prüfung deutscher Art": Der Alltag der Japanischen Medizinausbildung im Zeitalter der Reform von 1868 bis 1914* (Husum: Matthiesen Verlag, 2010); John Harley Warner, *Against the Spirit of System: The French Impulse in Nineteenth-Century American Medicine* (Princeton: Princeton University Press, 1998); and John Harley Warner, "The Selective Transport of Medical Knowledge: Antebellum American Physicians and Parisian Medical Therapeutics," *Bulletin of the History of Medicine*, 59 (1985): 213–31.
18. The American colonial period in the Philippines is an excellent example of this, see Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006).
19. Arnold, *Colonizing the Body*.
20. This was also true for the introduction of other forms of Western science. See Lewis Pyenson, *Civilizing Mission: Exact Sciences and French Overseas Expansion, 1830–1940* (Baltimore: The Johns Hopkins University Press, 1993).
21. See Hoang Bau Chau, "The Revival and Development of Vietnamese Traditional Medicine: Towards Keeping the Nation in Good Health," in *Southern Medicine*, ed. Monnais, Thompson, and Wahlberg, 133–52. On the larger trajectory in the West of the relationship between health and citizenship, see Oosterhuis and Huisman, "The Politics of Health and Citizenship."

22. Robert K. Merton, George G. Reader, and Patricia L. Kendall, *The Student-Physician: Introductory Studies in the Sociology of Medical Education* (Cambridge: Harvard University Press for the Commonwealth Fund, 1957); Renée C. Fox, *The Sociology of Medicine: A Participant Observer's View* (Englewood Cliffs, NJ: Prentice Hall, 1957); Renée C. Fox, *Experiment Perilous: Physicians and Patients Facing the Unknown* (New York: Free Press, 1959); Renée C. Fox, *Essays in Medical Sociology: Journeys into the Field* (New York: Wiley, 1979). See also Byron J. Good and Mary-Jo DelVecchio Good, "'Learning Medicine': The Constructing of Medical Knowledge at Harvard Medical School," in *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life*, ed. Shirley Lindenbaum and Margaret Lock (Berkeley: University of California Press, 1993), 81–107. Claire Wendland, in her study on medical education in Malawi, has provided one of the only sustained sociological and anthropological analyses of medical education in a non-Western setting: Claire Wendland, *A Heart for the Work: Journeys through an African Medical School* (Chicago: University of Chicago Press, 2010).
23. Warwick Anderson, "Science in the Philippines," *Philippine Studies* 55, no. 3 (2007): 287–318, 289, 298.
24. Liesbeth Hesselink, *Healers on the Colonial Market: Native Doctors and Midwives in the Dutch East Indies* (Leiden: KITLV Press, 2011).
25. Monnais-Rousselot, *Médecine et colonisation.*
26. Lenore Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870–1940* (Cambridge: Cambridge University Press, 1996), 15.
27. For an overview of the development of medicine in colonial empires, see Laurence Monnais and Hans Pols, "Health and Disease in the Colonies: Medicine in the Age of Empire," in *The Routledge History of Western Empires*, ed. Robert Aldrich and Kirsten McKenzie (London: Routledge, 2014), 270–84. See also Arnold, ed., *Warm Climates and Western Medicine*; Roy MacLeod and Milton Lewis, eds, *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988); and Michael A. Osborne, *The Emergence of Tropical Medicine in France* (Chicago: University of Chicago Press, 2014).
28. Arnold, *Colonizing the Body*; Guénel, "La lutte antivariolique."
29. Liew Kai Khiun, "Wats and Worms: The Activities of the Rockefeller Foundation's International Health Board in Southeast Asia (1913–1940)," in *Global Movements, Local Concerns: Medicine and Health in Southeast Asia*, ed. Laurence Monnais and Harold J. Cook (Singapore: NUS Press, 2012), 43–61, and Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–1965* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2006). For an analysis of initiatives in public health education in the United States, see Nancy Tomes, *The Gospel of*

Germs: Men, Women, and the Microbe in American Life (Cambridge: Harvard University Press, 1998).

30. For an overview of health activities on an international scale, see Anne-Emanuelle Birn, Yogan Pillay, and Timothy H. Holtz, "The Historical Origins of Modern Public Health," in *Textbook of International Health: Global Health in a Dynamic World* (New York: Oxford University Press, 2009), 17–60; and Paul Weindling, *International Health Organisations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 1995). See also John Farley, *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: University of British Columbia Press, 2008), and Javed Siddiqi, *World Health and World Politics: The World Health Organization and the UN System* (Columbus, SC: University of South Carolina Press, 1995).
31. Liesbeth Hesselink, "Nel Stokvis-Cohen Stuart (1881–1964) and Her Role in Educating Female Nurses and Midwives in the Dutch East Indies," in this volume, 38–66.
32. Annick Guénel, "Cattle for the Colony: Veterinary Science and Animal Breeding in Colonial Indochina," in this volume, 95–115.
33. After World War II, a great number of nurses from the Philippines migrated to the developed world to find employment. See Barbara L. Brush and Julie Sochalski, "International Nurse Migration: Lessons from the Philippines," *Policy, Politics, & Nursing Practice* 8, no. 1 (2007): 37–46. See also Anderson, *Colonial Pathologies*, 201–5.
34. For an overview of the activities of the China Medical Board in China, see Jennifer Ryan, Lincoln C. Chen, and Anthony J. Saich, eds, *Philanthropy for Health in China* (Bloomington: Indiana University Press, 2014).
35. A recent investigation of the Chinese barefoot doctors characterizes them as pioneers for introducing Western medicine to the Chinese countryside: Xiaoping Fang, *Barefoot Doctors and Western Medicine in China* (Rochester, NY: Rochester University Press, 2012). See also Jan Ovesen and Ing-Britt Trankell, *Cambodians and Their Doctors: A Medical Anthropology of Colonial and Post-Colonial Cambodia* (Copenhagen: NIAS Press, 2010).
36. Arnold, *Colonizing the Body*. See also Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Basingstoke and New York: Palgrave Macmillan, 2004), and Michael G. Vann, "Hanoi in the Time of Cholera: Epidemic Disease and Racial Power in the Colonial City," in *Global Movements*, ed. Monnais and Cook, 150–70.
37. See Shaun Kingsley Malarney, "Germ Theory, Hygiene and the Transcendence of 'Backwardness' in Revolutionary Vietnam (1954–60)," in *Southern Medicine for Southern People: Vietnamese Medicine in the Making*, ed. Laurence Monnais, C. Michele Thompson, and Ayo Wahlberg (Newcastle upon Tyne: Cambridge Scholars Publishing, 2012). See also Sokhieng Au, *Mixed Medicines: Health and Culture in French Colonial Cambodia* (Chicago: University of Chicago Press, 2011).

38. See also Eric Andrew Stein, "Hygiene and Decolonization: The Rockefeller Foundation and Indonesian Nationalism, 1933–1958," in *Science, Public Health, and the State in Modern Asia*, ed. Liping Bu, Darwin H. Stapleton, and Ka-Che Yip (New York: Routledge, 2012), 51–70.
39. We take the apt phrase "gospel of germs" from Tomes, *Gospel of Germs*. See Milton Lewis and Kerrie L. MacPherson, *Public Health in Asia and the Pacific: Historical and Comparative Perspectives* (New York: Routledge, 2007). For the Dutch East Indies, see Eric Andrew Stein, "Colonial Theatres of Proof: Representation and Laughter in 1930s Rockefeller Foundation Hygiene Cinema in Java," *Health and History* 8, no. 2 (2006): 14–44, and Liew Kai Khiun, "Wats and Worms." The work of Rockefeller representative John L. Hydrick on Java came to represent this form of intensive public health education. The manual he wrote for the 1937 Intergovernmental Conference on Rural Hygiene was widely disseminated: John L. Hydrick, *Intensive Rural Hygiene Work and Public Health Education of the Public Health Service of Netherlands India* (Batavia: Author, 1937). See also: Amrith, *Decolonizing Public Health*.
40. See, for example, John Ettling, *Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South* (Cambridge, MA: Harvard University Press, 1981); John Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913–1951)* (New York: Oxford University Press, 2004); Steven Palmer, *From Popular Medicine to Medical Populism: Doctors, Healers, and Public Power in Costa Rica, 1800–1940* (Durham, NC: Duke University Press, 2003); and Palmer, *Launching Global Health*.
41. Annick Guénel, "The 1937 Bandung Conference on Rural Hygiene: Toward a New Vision of Healthcare?," in *Global Movements, Local Concerns*, ed. Monnais and Cook, 62–80. See also Malarney, "Germ Theory"; and Robert D. Whitehurst, "Đặng Thùy Trâm and Her Family, Lives in Medicine," in *Southern Medicine*, ed. Monnais, Thompson, and Wahlberg, 85–106.
42. Sherman Cochran, *Chinese Medicine Men: Consumer Culture in China and Southeast Asia* (Cambridge: Harvard University Press, 2006).
43. See also Laurence Monnais, "Traditional, Complementary and Perhaps Scientific? Professional Views of Vietnamese Medicine in the Age of French Colonialism," in *Southern Medicine*, ed. Monnais, Thompson, and Wahlberg, 61–84.
44. See, for example, the essays in Hoang Bao Chau, ed., *Vietnamese Traditional Medicine* (Hanoi: The Gioi, 1999); Ayo Wahlberg, "A Revolutionary Movement to Bring Traditional Medicine Back to the Grassroots Level: On the Biopoliticization of Herbal Medicine in Vietnam," in *Global Movements*, ed. Monnais and Cook, 207–25; and Guy Attewell, *Refiguring Unani Tibb: Plural Healing in Late Colonial India* (New Delhi: Orient Longman, 2007).

45. For the international activities of the Rockefeller Foundation, see William H. Schneider, *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War I to the Cold War* (Bloomington: Indiana University Press, 2002); John Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913–1951)* (New York: Oxford University Press, 2004); Liew Kai Khun "Wats and Worms"; and Palmer, *Launching Global Health*.
46. For an overview of both health matters in Siam in the early twentieth century, see Executive Committee of the Eighth Congress of the Far Eastern Association of Tropical Medicine, *Siam in 1930: General and Medical Features* (reprint) (Bangkok: White Lotus, 2000).
47. For an overview of Thai worries about communism in Asia and the relationship between the Thai monarchy and the Thai Buddhist sangha, see Charles F. Keyes, *Thailand: Buddhist Kingdom as Modern Nation State* (Boulder, CO: Westview, 1987).
48. For WHO initiatives promoting indigenous medicine, see Socrates Litsios, "The Long and Difficult Road to Alma Ata: A Personal Reflection," *International Journal of Health Services* 32 (2002): 709–32. See also, for example, R. Kusumanto Setyonegoro and W.R. Roan, *Traditional Healing Practices: Proceedings, ASEAN Mental Health Teaching Seminar on Traditional Healing, Jakarta, Indonesia, Dec. 3–9, 1979* (Jakarta: Ministry of Health, 1983).
49. See Ruth Richardson, *Death, Dissection, and the Destitute*, 2nd edition with a new afterword (Chicago: University of Chicago, 2000); Helen MacDonald, *Human Remains: Dissection and Its Histories* (New Haven: Yale University Press, 2006); Michael Sappol, *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth-Century America* (Princeton: Princeton University Press, 2002); and John Harley Warner and James E. Edmonson, *Dissection: Photographs of a Rite of Passage in American Medicine, 1880–1930* (New York: Blast Books, 2009).
50. Geerlof Wassink, quoted in Hesselink, *Healers on the Colonial Market*, 139.
51. We use Ruth Rogaski's term in the expansive sense she develops in *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley: University of California Press, 2004).
52. Liesbeth Hesselink, "Nel Stokvis-Cohen Stuart (1881–1964) and Her Role in Educating Female Nurses and Midwives in the Dutch East Indies," in this volume, 38–66.
53. Helpful here is Simon Schaffer, Lissa Roberts, Kapil Raj, and James Delbourgo, eds, *The Brokered World: Go-Betweens and Global Intelligence, 1770–1820* (Sagamore Beach, MA: Science History Publications, 2009).
54. Helpful here are Michael W. Apple, *Ideology and Curriculum* (London: Routledge & Kegan Paul, 1979), and Michael W. Apple and Kristen L.

Buras, eds, *The Subaltern Speak: Curriculum, Power, and Educational Struggles* (New York: Routledge, 2006).

55. Hoang Bau Chau, "Revival and Development."
56. See, for example, David Arnold, "Tropical Governance: Managing Health in Monsoon Asia, 1908–1938," ARI *Working Paper*, no. 116 (2009), http://www.nus.ari.edu.sg/pub/wps.htmm; see also Deborah Neill, *Networks in Tropical Medicine: Internationalism, Colonialism, and the Rise of a Medical Specialty, 1890–1930* (Stanford: Stanford University Press, 2012), and Amrith, *Decolonizing International Health*.