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Tongan Doctors and a Critical Medical Ethnography[1]

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Since 2001, I have been doing research on Tongan doctors.

Take a moment to reflect on that statement. What does it mean, to you? Did you experience a moment of confusion? Generally, when I say 'I'm researching Tongan doctors', I am met with a request for clarification. This happens even when I am speaking to other anthropologists: 'Oh, you mean traditional medicine?' Or, 'Do you mean indigenous healers?' I have even been asked: 'You mean, um, witch-doctors, shamans, err …?'

No.

When I say 'Tongan doctor', I am referring to someone who has graduated from a recognised and accredited medical school, who is practising within government-sanctioned guidelines as a professional physician, and who also happens to be indigenous to the Polynesian nation of Tonga.

This paper is motivated both by the confusion I have encountered when I say 'Tongan doctor', and a desire to liberate the story of how Tongans came to have 'modern' biomedical services. I believe the confusion and the history of the first Tongans to try to become doctors have relevance for a critical ethnography of medicine. Given the self-reflexive and 'anti-savage slot' emphasis in contemporary anthropology, and given critical medical anthropology's particular emphasis on the cultural situatedness of biomedicine, the puzzled responses I have encountered in professional contexts should not occur. 'Tongan doctor' should be no more confusing than 'Canadian' or 'Australian' or 'French doctor'. That I have experienced these requests for clarity on several occasions, most remarkably at the American Anthropological Association meetings in 2002, implies that the kinds of essentialisms anthropologists purport to gainsay, and that the first advocates for a Pacific Islanders' medical school faced in the early twentieth century, are still in place decades later. Juxtaposing vignettes of the colonial-era encounter between Tongans and Western medical professionals with contemporary anthropological discourses allows me both to liberate elided social histories—stories contradicting the usual assumption that elements of Western modernity are generally imposed on indigenous people—and to

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collapse the sense of intellectual progress over time that is presumed in our usual discourse. In the process, I hope to demonstrate a kind of historically contextualised, personally engaged, long-term ethnography that I think any critical ethnography of medicine must include.

The Lavender Thief

Tonga began training medical students in 1928. The first four students were selected by a simple procedure. Just before Christmas, at the end of the school term, the Prime Minister's office informed the top two graduates from each of Tonga's two high schools that they were being sent to Suva, Fiji, to become doctors. School term began in January. After only a week's notice, four young men, Sione 'Kuli' Helu, Tamata'ane Tonga, Tevita Silafou Palu and Sione Posesi Fanua were on a boat, steaming to Fiji. Three years later, in 1931, the first Tongans trained in Western biomedical techniques returned home to begin working as doctors. However, whereas four had left to study, only three graduated. The story of the fourth, Tamata'ane Tonga, illuminates colonial ideas regarding medicine, indigenous peoples, and regimes of control and authority. It also presages the confusion of roles and identities surrounding the idea of the 'Tongan doctor' that my colleagues continue to demonstrate.

Tamata'ane's name appears relatively frequently in the early record books from the Central Medical School. Intellectually bright, and as competent as any other student, he was, it appears, a problem. He frustrated the head of the school and the hospital teaching staff with numerous breaches of conduct. His escapades included sneaking into the nurses' dormitory after dark; going into town to visit the bars and social clubs against curfew; contradicting and refusing to obey the nursing Matron; acting superior to the other Pacific Islanders; and, ultimately, stealing. Despite the facts that he was almost ready to graduate, that the Tongan government had already invested three years of tuition and accommodation expenses and needed his services, and that he was regarded as a bright and highly competent medical student, Tamata'ane Tonga was expelled.

What was the theft that resulted in the first expulsion from the Suva Medical School? Sione Numa, a Cook Islander who himself would go on to become a well-respected graduate (Numa 1965), wanted to go into town to drink kava and flirt with girls. He asked Tamata'ane to sneak into the dispensary and bring back some tincture of lavender to perfume their coconut oil. The game of young men in their early 20s sneaking out for romantic conquests is a particular chiefly form of play in Polynesian societies. I am sure the boys were thinking of the power of a new and exotic scent, lavender, and the influence it would have over the girls who would be serving the kava. However, it is also likely that the challenge of sneaking into the dispensary was a significant part of the fun. Tamata'ane accepted the task and was successful, but the boys were also caught. This was the last straw. The tendency for all of the Tongan students to act 'lordly' and 'high and mighty' in contrast to the other Pacific Islands

students, and Tamata'ane's consistent insubordination, had already irritated the medical school faculty. An example was to be made.

Medicine and Indigenous Modernity

The project I am still in the middle of aims at documenting the contribution of health-care training, medical policy and, especially, indigenous Tongan health-care professionals to the process of political, social and cultural indigenous modernity-making in Tonga, from the late eighteenth century to the twenty-first century. Following Foucault (1973), theorists have begun to identify medicine's place in the production of colonial empires, colonist and colonised identities (Cohn 1996), regulated bodies (Comaroff 1985, 1993) and racial inequities (Fanon 1978; Stoler 1995). However, the tendency has been to emphasise the changes wrought by the actions of foreigners and, ultimately, to represent indigenous peoples as passive recipients of colonising and modernising forces. I am interested in the way in which biomedicine—as a corpus of knowledge and practices that continually constitutes itself as 'modern'—served as a vehicle in the conscious strategies of the Tongan monarchy to retain self-governance while joining the 'civilised world'.[2] Tongans today proudly claim to be the only Pacific nation to have evaded colonisation (Vaea 1997, cited in Morton 2001, 38), and I contend that one aspect of the strategy to evade the fate of other Polynesians was the careful and purposeful selection of certain forms of 'modernity'. Today, contemporary Tongans live in a society and economy that is still highly oriented towards kinship-based responsibilities, subsistence agriculture and smallholder production, with well-entrenched Polynesian-style forms of hierarchy, prestige, reciprocity and ritual. Theirs is also a society that is rapidly and purposefully embracing a globalised modernity in ways that sometimes deleteriously affect population health (Young Leslie 2002, 2004; Evans *et al.* 2002), while confirming and confounding some characterisations of the modernisation process in 'expert systems', of which biomedicine is one example (Giddens 1990).

Tonga has a socialised medical system and most physicians work for the government's Ministry of Health, which often funds their medical school scholarships. At any one time in Tonga today, for a population of approximately 100,000, there are some 35 medical doctors working in hospitals, clinics and private practice. They are specialists in obstetrics, pediatrics, psychiatry, internal medicine and various special surgeries, including plastics. The gender balance is close to equal, they are among the best-paid civil servants in the country, and their large houses demonstrate their relative prosperity. Many Tongan doctors' children attend Montessori, English-immersion or other specialty schools, and travel overseas for secondary education. There are many other doctors who have left and are now working overseas—in New Zealand, Australia, Fiji and the USA—where their skills and expertise with indigenous Pacific Islanders' cultures are valued. Several have postgraduate degrees, such as Master's degrees in public health and health promotion; postgraduate certificates in leprosy management, tuberculosis or malaria control, ultra sound and

x-ray diagnosis; or extra training in special surgical procedures such as ocular or orthopedic surgery. Many have been seconded as consultants to the WHO, UNICEF or other international health agencies. Tonga's contemporary medical service, which indigenous Tongan men and women control and dominate, contrasts markedly with other, wealthier Pacific and postcolonial nations. New Zealand, for example, has a large Polynesian population but relatively few indigenous persons working as medical professionals, a problem that elicits tension (see Goldsmith this issue). The Tongan medical system, in one sense, fits within Giddens's description of the 'expert system', and in broad outlines matches biomedicine in other nations. At the same time, Tongan society has not surrendered the cultural forms of time and personhood that are described as 'traditional' and assumed lost when modernity arrives. In Tonga, funerals and other major kinship obligations are acceptable reasons for missing work. I know obstetricians and plastic surgeons who farm their own food crops, a pediatrician who weaves pandanus mats, and some who value their music or family life as much as their career. At the tertiary care hospital, the operating theatre has been Tonganised: people who have a classificatory brother–sister relationship will not be scheduled to work in the same surgery if it entails exposure of the patient's genitalia, because brothers and sisters should not witness such sights while together. In sum, Tongans exhibit what Sahlins (1999) refers to as an 'indigenous modernity'.

Why Tongan Doctors?

I became interested in the question of the Tongan medical service while living in northern Canada. A recurrent problem in the northern and especially aboriginal communities was trouble getting, keeping, and communicating with, doctors. A second problem was getting aboriginal students into and through medical programs. This problem exists across the indigenous and colonised world. Tongans, I knew from my initial research (Young Leslie 1999), had none of these problems. They did not need a translator at the hospital. They did not fear that their doctor would ask for something culturally inappropriate. They were not surprised that their doctor spoke their language. Moreover, medical school scholarships were not considered quota-driven handouts. In short, Tongans had almost none of the problems dealing with the medical profession reported by indigenous people elsewhere. How did this come to be, and why was the Tongan example of indigenous physicians not better known?

I began by asking Tongan doctors whom I knew as friends about their medical system: how it started, who it started with, why so many physicians train in Fiji, what it was like for them to study Western-based biomedicine with its quite different ways of characterising the human body and social realities? What struck me was the dearth of knowledge, among the general public as well as the doctors, about the medical service's development, coupled with enthusiasm for the idea of a book about it. Some people could tell me names of old doctors, others referred to places where the old hospital had been located, yet others spoke of well-known characters and told me to 'ask so-and-so; he might know'. Nevertheless, there was a clear lack of official rhetoric

and dialogue about the Tongan medical system, which in itself was strange. In my experience, whenever a (stereotypical) anthropological or historical question is raised in Tonga—be it about ritual, kinship, food production, religion, gender relations, the economy, education or traditional healing—there is always an 'official view'. Tongans are very conscious of their culture, and both reflective and protective of it. I was simply not used to a topic for which there was no official rhetoric. Furthermore, no records documenting the establishment of the medical system and no lists of Tongan recipients of medical scholarships seemed to exist. I admit that the mystery appealed to me, but so did the opportunity to offer an ethnographic example that confounded so many political and anthropological stereotypes about both 'Natives' and biomedicine. In Tonga, I was urged to hurry as one well-respected (and long-lived) doctor had died only a few years previously (several more have passed since I began).

My project combines archival research in Fiji, England[3] and Tonga with interviews, discussions and participant observation with Tongan physicians. I began the project by targeting the most elderly (most were still working). I also spent weeks in various archives and repositories. I delved through dusty, gecko-filled bookshelves and mildewed boxes at the Fiji School of Medicine, at the Vaiola Hospital in Tonga and in one dank copra shed in Nuku'alofa. I assisted with medical consultations, attended the Tongan Medical Association (TMA) conference, contributed to the TMA's weekly meetings, gave a report on the Pacific Region Indigenous Doctors' Congress, observed in the operating theatre and private clinics, went out for lunch, dinner and coffee with doctors, and even sang karaoke at the doctors' favourite bar.

The findings that most interested my interlocutors were the contents of the record books from the first years of the Central Medical School, the personnel files from now-deceased Tongan doctors and correspondence between colonial officials. An archivist's nightmare, the books and file folders were falling apart, but they were a gold mine of history. Combined with my interviews and my time with current practitioners, they reveal ongoing tensions of culture, race, gender, social status, and being 'modern' or 'civilised'. While I like to think I have broadened my interlocutors' understanding of what anthropology is, historic stereotypes about Tongan doctor-trainees seem to be repeating themselves in my professional present.

Of Colonials and Cannibals

> There were forty native medical practitioners—natives given a three-year course in simple medicine and surgery … Some of these boys, though taught so little surgical practice, developed great ability; it was almost as though their cannibal ancestry had given them a particular flair for human anatomy. (Lambert 1941, 122)

The writer is Sylvester Lambert MD, the Rockefeller Foundation's Hookworm Control Officer in the Pacific from 1922 until 1927. Lambert (1941, 284) was a major proponent for the development of a medical school in Fiji, one that would 'send all over the Pacific, bring in eligible native boys, and teach them what modern medicine really means'.[4] He was also a stout defender of Pacific Islanders' intellects. While the

notion of a cannibal ancestry predisposing students for medicine might be taken as a jocular nod to the overwhelming importance of anatomy in the practice and ideology of medical training (Foucault 1973; Lella and Pawluch 1988), it is also an example of the kind of race-based essentialism that permeated even liberal discourses of the early twentieth century. Lambert's complex attitudes towards the people he intended to assist, and claimed to respect, are a useful reminder of the social context in which racial and gendered hierarchies were an issue, both for the social liberals who sought to create a medical training program, and for those early Pacific Islands medical students who sought to become doctors.

Ironically, while the students went to become doctors, and were put to work as such when they returned home, their graduation certificates called them Native (later Assistant) Medical Practitioners (NMP). As the brothers Fakava'inga and Samuela Taumoepeau told me: 'We thought we were going to be doctors'. Nevertheless, when it came time to graduate, 'we found out we were just NMPs' (interview August 1999). The three-year course of study was not considered rigorous enough by foreign physicians for the Pacific Islands graduates to be considered real doctors, a fact that enormously surprised and dismayed the Tongan government. It meant that, counter to the entire point of the medical training scheme, the Tongan medical service remained under the control of a foreign Chief Medical Officer. This remained the case until, after completing his NMP, a Tongan named Sione Tapa graduated from the Otago medical school in the 1950s (Young Leslie 2004).

Reminiscences like Lambert's, and stories like those of Tamata'ane's and the Taumoepeau brothers, point to the complex interplay that permeated both the colonial encounter and the practice of medicine in the Pacific during the colonial period. The stories are fascinating, but is this a critical ethnography? I think it is a beginning. To history must be added aspects of what West (this issue) calls 'ethnographic sociality', what Tuhiwai Smith (1999) calls 'insider research' and what Tongans call *fetu'utaki*.

Towards a Critical Medical Ethnography

My understanding of critical ethnography draws on and is framed by my understanding of 'critical interpretive medical anthropology' (Lock and Scheper-Hughes 1996). Contemporary critical medical anthropologists in North America and the UK (at least) embrace three key principles. First, there is an *anti-inequity* agenda, which aims to counter the injustices, hegemonies and capillary power relations that disenfranchise and harm people. Second, there is *reflexivity*: we, too, are embedded in a global capitalist system and we, too, are influenced by culture. Social processes and power relations that affect the people we study also affect us. Third, there is *a refiguring of the anthropological subject*, especially a rejection of the idea that those whom anthropologists study are by default ethnic, cultural or indigenous 'others', that they are, somehow, exotic underdogs.

To accomplish the first principle means asking tough questions of the present and the past about the unequal distribution of illness, medicines and types of diagnoses, as well as medical services, education and other privileges. The reflexive stance required of the second principle means it is important to understand how the biomedical knowledge and ideologies that are penetrating globally are created and reproduced. In other words, reapply the feminist slogan from my youth (the personal *is* political), and refuse to be deluded by the mystique of 'research' for research's sake. This means the answer to Petersen's 'For whom?' question (this issue) is that the research is for *them*—in my case, Tongans. My understanding of this comes as much from living and working with or on the margins of indigenous and feminist issues in Canada, as from Tongans and the work of other Pacific scholars, including Hau'ofa (1994) and Tuhiwai Smith (1999). I want to expand on this point before discussing the third principle, because it directly affects and is affected by my relationship with Tonga and Tongans.

Fairytale Ethnography and Personal Engagement

I started out doing fairytale ethnography: the whole distant island, foreign language, isolated, tiny community, deep participant observation, heroine-ethnographer thing (see Young Leslie 1998, 1999). Over the past dozen years, my relationship to that original community and other Tongans has grown markedly. I am now positioned in ways both inside and outside. I am incredibly privileged:[5] I am permitted to use a particular pair of ceremonial names in certain ritual settings, and I have been allocated land on which I am encouraged to build a house. I am told I am now a '*fefine ha'ano*', a woman of the village. I have surrogate/fictive/adoptive children whose education I help to support, just like any other 'aunty' with a good job. At the same time, children who played in my house in the early 1990s now call me on their cell phones to chat, or email me with the latest news. In my research with doctors, and because of my past as a nurse, I have a different and yet mutually supportive relationship with some of the doctors who constitute my research 'subjects'. We email and share medical and health promotion information, and we visit when we are in the same country. As much as we talk about professional aspirations, medical issues or the book I am researching, we share stories about our families and emotional lives. I give them copies of my papers, and they buy me lunch. I am, in short, emotionally and socially embedded in communities and networks, such that when I am there, it no longer feels like 'away', and when I leave, I experience culture shock.

West (this issue) refers to this type of interpersonal closeness as 'ethnographic sociality', but I have been thinking of it as a kind of 'halfie-ness'. Abu-Lughod's (1990) notion of the halfie anthropologist was intended to describe the sense of being in two positions, having two identities, at once. However, where Abu-Lughod attributes 'halfie' to (mostly) mixtures of nationality and ancestry, mine is totally acquired and experiential. I am too aware of indigenous identity politics and the

potential for accusations of White appropriation to claim to *be* a 'halfie'. Yet I am now something more than, and very different from, the 'professional stranger' type of ethnographer (Agar 1996), whose goal is simply to do good, relevant research.[6] Perhaps I am a trickster (van Meijl this issue), but I am not sure. My commitments are now as much to the family I have there as to my birth daughter and natal kin. Whereas anthropologists are often thought of as maintaining relationships with their interlocutors for the sake of their careers, such that the researched are a necessary convenience, in my case my job as a university professor is the necessary convenience that permits me to fulfil my acquired obligations. I take my cues from their interests, and I discuss my current and potential research with them over tea, cappuccino, taro and kava. I can describe this relationship best in Tongan, with the terms *tauhi va* and *fetu'utaki*, caring for the relationship through familiarity marked by back and forth communication. I am, as I say, very privileged.

I also know this embedded complex of loyalties would not have developed if I had not done the fairytale ethnography first. That was where people taught me how to be Tongan, and set the ground for me to prove myself in their eyes. Also relevant is the fact that we have sustained a relationship over a dozen years now, and that Tongans do not feel constrained by the kinds of de-colonisation work being done in Oceania, Canada and elsewhere. This long-term, gradual building of a relationship, plus the freedom to be included, are perhaps what set my research apart from other much more extensive (and contentious) historical ethnographies, such as those of Sahlins (1981, 1995) and Obeyesekere (1992). While I do not have space here to discuss their debate, I agree with Borofsky (1997) that both scholars were talking past each other and past the Hawaiians they purported to be describing. This is vital, as is Borofsky's call for communication and common points of reference. Good communication requires a personally engaged ethnography, one that shrinks the insider/outsider distinction. Tengan's example of embeddedness within, and listening to, his audience(s) and West's descriptions of her ethnographic sociality (both in this issue) collapse the 'divide' that used to exist methodologically between researchers and researched. In one sense, anthropology has always tended to elide this divide, but, in another sense, it has forgotten the importance of personal engagement (Hymes 1999, 47–48). True personal engagement, developed with those among whom we cultivate research relationships, collapses 'difference' and emphasises shared humanity, while highlighting unequal privileges and disparities. When that divide collapses, there is no surprise at all at the idea of a *Tongan* doctor.

Returning finally to the third principle of critical medical anthropology, the one that emphasises biomedicine's own cultural situatedness and rejects the notion that our natural ethnographic subject is the 'other', the implication is that my current research on Tongan doctors falls well within the bounds of the discourse. It is not 'cutting edge' for a medical anthropologist to be doing the ethnography of doctors. What *seems* different is that the doctors I am interested in are Tongan.

So, what can we learn from the stories of Tongan doctors? In part, the laudatory histories of the unrecognised pioneers who Tonganised biomedical services are worth

telling. Also, it is a mistake to assume that indigenous people are passive victims in the face of global hegemonies and are not active in their own modernity. Finally, these vignettes demonstrate slippage between perceptions (even amongst ourselves) of what it is anthropologists do, the colonial past and our supposedly post-savage-slot present: Tamata'ane Tonga had a hard time being accepted as an equal, even though he was in a program designed to make him into one. In his eagerness to praise his 'native boys', Sylvester Lambert documents the racialised hierarchy in which Pacific Islanders first learned biomedicine. The Taumoepeau brothers worked as doctors their entire lives, confused by the fact that their professional designation was 'Native Medical Practitioner'. When I went to the AAA meetings to give a paper about Tongan doctors, I had to clarify that I was not talking about 'traditional healers' or 'shamans'. In harkening to these various instances, I have found a puzzling and embarrassing collapse of time and perception between the colonial era and present day. We all ought to know better! Thus, my paper is both about a critical ethnographic approach, which is historical, long-term and personally engaged, and critical of anthropologists' non-critical assumptions. In my personal experience, some contemporary anthropologists who belong to the twenty-first century still foreground the 'savage slot', despite professional rhetoric and efforts to gainsay it.

Notes

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[2] I am paraphrasing various physicians and various published statements of Queen Sālote herself, that have used the English term 'civilised' to refer to industrialised, modern societies.

[3] The Western Pacific High Commission records were located in Milton Keynes, England. They have recently been relocated to the University of Auckland.

[4] Pointedly, they were not girls, despite letters of request from various Oceanic administrators.

[5] While this kind of reflexive exposure is entrenched in feminist practice, it is not so easy to do from a Tongan perspective. It is as if the *'ofa* (love/generosity/empathy) I have received and shared is the only 'passport' I possess to legitimising my words. Putting it on display unpleasantly objectifies the gifts I have received, which is not my desire.

[6] While Tongans do not have this particular designation, I am something more akin to the *whangai* (adopted) model of researcher described in Tuhiwai Smith (1999, 177), at least in certain specific constituencies in Tonga.

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