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Archipelagic memories at Lau King Howe Hospital Memorial Museum

Malaysia is split by a body of water into the peninsula (West Malaysia) and the eastern states of Sabah and Sarawak (East Malaysia) on Borneo Island, which in turn is part of the Sunda Islands archipelagic cluster.¹ This collection of territories with diverse political structures is interconnected through shared colonial histories and inherited institutional traditions, in turn, rooted in the ways in which colonisation developed in these culturally distinctive and physically different geographical territories. British control of a number of 'Malayan' territories dates from the late eighteenth century onwards until 1957 and includes the colonial Straits Settlements: Penang, Melaka, and Singapore. Singapore was part of the post-independence Malayan Federation briefly from 1963 to 1965. East Malaysia, this article's focus, initially governed by a British agent, was an independent colony that subsequently joined and remained part of the federation. Architecture historian John Ting's extensive research on Sarawak's urban development helps situate this geopolitical history in settlements developed along riverine networks, as different from Malaya's colonial port cities.²

This article forms part of a larger research project that studies institutional development in Malaysia through hospitals established in parallel in the capital cities of these three different territories. The colonial network of medical institutions, typically concentrated in Singapore, spread throughout Malaya during the early twentieth century, linking both territories through a shared colonial history that saw the first European hospitals and medical schools established in Singapore before expanding to other regions of Malaya.³ The focus on hospital architecture offers insights into Malaya's medical history, explored by medical anthropologist Lenore Manderson through colonial public health policies.⁴ Developments in East Malaysia suggest the parallel evolution of medical institutions during the post-independence nation-building era. As noted by Sandra Khor Manickam, given the region's ethnocultural complexity, including Indigenous (First Nations) communities, it is important to understand how Indigenous experiences are interpreted within these institutional memories.⁵ This article explores how evidence of these particularities in hospital museums offers new insights into institutional histories.

Lai Chee Kien's seminal work on Kuala Lumpur has convincingly demonstrated that institutional design in former colonies expresses professional commitment

to self-determination through their form and aesthetics.⁶ Key development indices providing evidence of these changes include the rising standards of healthcare provision through numerical increases in, and the expansion of, extant hospital facilities, which demonstrate the post-independence government's investment in its population's health and welfare, alongside the training of medical professionals and support staff. A broad understanding of these activities enables comparison of how general hospitals were governed in different contexts, including their demographic complexity. In Malaysia, increased regional migration during British colonial rule created a multi-ethnic society with segregation based on race and class, including differentiated practices of care and opportunity. After independence, the medical duty of care required respecting and recognising diverse cultural needs. However, systemic colonial policies of racialisation sometimes persisted and became embedded in healthcare policy and institutional reform during the nation-building decades. The hospital, as it transitioned across the political event of independence, offers valuable insights into the relational histories of institutional decolonisation in each locality.

This article is divided into two sections. Section 1 elaborates on key features that distinguish East from West Malaysia, as viewed through the lens of its plural social composition, spatial networks, and institutional memories. Section 2 discusses the post-independence transformations to the medical institutions in Sarawak as the context for fieldwork at a specific medical museum site. It focuses, first, on Sarawak General Hospital, followed by Lau King Howe Hospital Memorial Museum (LKHHMM), situating each institution within the historical development of their respective cities: Kuching and Sibü. There is a paucity of historical records on hospitals in Malaysia, in general, and in East Malaysia, in particular, making the hospital museum an important archive of the transition from colonial to postcolonial political systems and processes, in particular, its adaptation of the plural political model. These complexities are further revealed through multivocal constructions of historical memory.

While the hospital's community and progress are commemorated through in-house publications such as *100 Years: Sarawak General Hospital Kuching 1910–2010*, the lack of an on-site museum prompted the investigation of a unique museum facility in the neighbouring Sibü district. A visit to the LKHHMM in Sibü, Sarawak, provided the provocation for exploring the historical relationship between East Malaysia's Indigenous communities and the colonial institution first introduced to Malaya in the late nineteenth century. It enabled comparison of the general hospital with the community hospital, which, in this example, is funded by a Chinese migrant minority. In the absence of the original building, the hospital museum has proven to be a significant repository of memories and experiences that reveal Malaysia's multicultural composition. The conclusion discusses the value of interpreting hospital architecture through archipelagic memories. The phrase is evocative of East Malaysia's disconnection, geographically and politically, from the Malayan peninsula, isolating and connecting it in different ways.

Section 1: Peninsula and the archipelago

Plural social composition

Sarawak, as part of Borneo Island, belongs to Southeast Asia's archipelagic island territories, and its spatial organisation, historical development, and sociocultural diversity reflect patterns more typical of island chains than of a contiguous landmass like West Malaysia. Despite occupying part of a larger island, Sarawak's dispersed riverine communities, uneven infrastructure, and distinct cultural regions create a functional geography defined by isolation, nodal connectivity, the jungle-produce trade, and uneven development.⁷ Scholarly work on watershed-based social networks further highlights the need to view connectivity and placemaking as shaped primarily by riverine mobility.⁸ Recognising Sarawak's 'archipelagic' qualities thus offers a valuable lens for understanding governance, Indigenous identity, memory, and development across its interior and coastal regions.

Geographic separation gave rise to different systems of colonial government on the Malayan peninsula and Borneo island.⁹ There was a centralised and hierarchical system of government adopted on the Malayan peninsula with colonial administrators in the Straits Settlements (Singapore, Penang, and Province Wellesley and, briefly, Dinding and Melaka) and local administration by Rajahs or chieftains, including in Selangor, the state in which Kuala Lumpur is located.¹⁰ In contrast, the Brookes, a family of British adventurers, ruled Sarawak as a sovereign state under a hereditary monarchy from as early as 1841.¹¹ Across three generations until 1946, the so-called White Rajahs of Sarawak controlled this territory. British reluctance to incorporate Sarawak as a colony, limited resources to challenge Indigenous jurisdiction, and Brunei's status as a Sultanate, and later a British protectorate in 1888, created conditions for a different approach to sovereignty, resulting in the Brooke administration developing Sarawak's infrastructure independently and more slowly than that of the Western Peninsula, which benefited from stronger institutional support for developing infrastructure and closer integration with the colonial network.¹²

Malaysia's pluralistic state ideology seeks to unify colonial-era racial categories while respecting multi-racial and multi-religious identities. Yet the colonial structure of racialisation was carried into the post-independence administration. This process was most strongly institutionalised in West Malaysia, unlike in Sabah and Sarawak, where colonial rule engaged a wider spectrum of Indigenous groups through categories such as *bumiputera* in Malaysia. *Bumiputera*, translated as "son of the land," is an administrative and political designation of Malays and some Indigenous peoples of Peninsular and East Malaysia. This category is distinct from non-*bumiputera* who are designated as Chinese, Indian, and ethnic 'others.' This collective categorisation of precolonial Indigenous communities is often used in contrast to settler or migrant groups and is mirrored in Indonesia's *pribumi* designation.¹³ Although *bumiputera* and *pribumi* are used in Malaysian academic contexts, and as transnational categories, only *bumiputera* is formalised as a legal definition with constitutional identity and benefits. This was initially mandated in Malaysia's Federal Constitution in 1957, which specifies the "special position" of Malays, Indigenous peoples, and First Nations or *orang asli*, requiring government protection through economic and educational measures.¹⁴ Although the formal policies to institutionalise the term *bumiputera* only

emerged in 1971, after the 13 May racial riots of 1969, the colonial practice of collectivist classifications of Malays and Indigenous groups persisted and evolved throughout the country's postcolonial development journey.¹⁵ The problems related to *bumiputera* demographic absorption surfaced decades later due to economic imbalance caused by government development policies.¹⁶

Because of its autonomy and different administrative system, Sabah and Sarawak on Borneo Island maintained the diversity and numerical advantage of Indigenous populations, including, but not limited to, the Bataks, Bisayaks, Dayaks, Dusun, Kedayan, Kelabits, Kenyahs, Melanau, Murut, Punan, and Sekapan, who maintain their separate identities and languages. Openness to cultural and religious diversity shaped policies on patient classification and healthcare. Figure 1 is an extract from the Annual Reports by the Medical and Health Department of Kuching General Hospital, which describes the breakdown in patient nationalities admitted to Kuching General Hospital, Sarawak, in 1948.¹⁷ Now named Sarawak General Hospital, it provided medical services to all major towns and deployed remote medical services via travelling medical contingents.¹⁸

The report accounts for thirteen groups alongside regional migrants and some foreigners (American and Australian), including Indigenous communities from both Borneo and Indonesia. This granular approach to racial categorisation was absent in colonial [West] Malaya and Singapore, and persisted past independence in the adoption of broader plural categories that assimilated the many linguistically diverse tribal groups under Malays.¹⁹ Such categorisation produced a different Indigenous-to-migrant dynamic in West Malaysia compared to the East.

Fig. 1 Medical and Health
Department of Kuching General
Hospital, Sarawak (1950).
Nationalities of patients admitted
to Kuching General Hospital in 1948
[National Archives, United Kingdom]

(xiv)

Appendix VI.

GENERAL HOSPITAL, KUCHING, 1948.

<i>In-Patients.</i>				
Total number of admissions during the year	..	..	..	5,510
Total number of male patients admitted during the year	..	..	..	2,671
Total number of female patients admitted during the year	..	..	..	2,839
<i>Nationalities.</i>				
Americans	..	..	..	2
Australian	..	..	..	5
Bisayah	..	..	..	2
Bataks	..	..	..	5
Chinese	..	..	..	3,636
Dayaks	..	..	..	1,004
Dusuns	..	..	..	5
Europeans	..	..	..	85
Eurasians	..	..	..	23
Indians	..	..	..	162
Japanese	..	..	..	1
Javanese	..	..	..	43
Kadayan	..	..	..	1
Kayans	..	..	..	3
Kanowit	..	..	..	1
Kelabits	..	..	..	2
Malays	..	..	..	506
Mamaloh	..	..	..	2
Melanaus	..	..	..	14
Murut	..	..	..	5
Philipinos	..	..	..	3
TOTAL				5,510

The scarcity of comparable institutional evidence differentiating Indigenous from Malay-Muslim identity (or Indigenous Christian identities) highlights their structural absorption in West Malaysia by the mid-twentieth century. In contrast, the census figures for Sarawak in 1947, documented by L. W. Jones, identify the Iban (Sea Dayak) at 34.8 per cent as the largest community (exceeding the Chinese at 26.6 per cent).²⁰ Ten Indigenous groups are named, including the Malays. Likewise, in his study of Borneo during World War II, Ooi Keat Gin observes that, unlike in other colonial territories, “Brooke paternalism enacted legislation to shield native peoples from all forms of exploitation by both Chinese and Europeans, especially in matters related to land acquisition and utilization.”²¹ He notes that Brooke’s regular army, the Sarawak Rangers, largely consisted of Iban recruits.²² The excerpt in Figure 1, from the National Archives of Britain, where each patient was categorised by ‘race’ or ‘nationality,’ corroborates the persistence of Indigenous identification in postwar Sarawak (1948–49).²³

Spatial networks

The diverse geographical conditions of each colonial territory’s capital cities influenced where general hospitals were built. Colonial general hospitals expanded by merging European and pauper hospitals to serve broader non-European (Chinese, Indian, Malay) urban communities that supplied labour for the colonial economy. By the twentieth century, these institutions had become self-contained campuses linked with other hospitals in capital cities through expert exchange and specialisation development. They were typically built by the colonial public works department and included experiments in tropical hospital design.

While these campus configurations might be considered the nodal points in each geography, a range of smaller institutions existed alongside them. Notably, community hospitals established by immigrant philanthropists initially emerged to counter the colonial government’s neglect of its population and were found in both urban and rural areas. They were seen initially as pauper hospitals or charitable institutions because they catered to the local population and non-European migrant workers. Rural hospitals were outliers in this spatial configuration and can be recognised as simple spaces within the homes of healers (*bomohs*, *sinseh*,

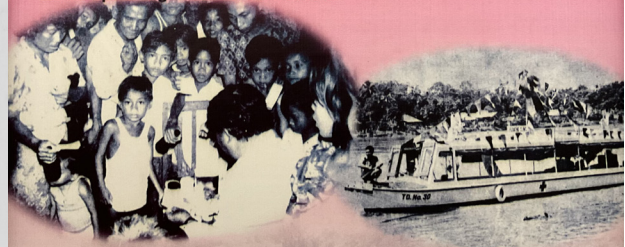
Fig. 2 Two boat styles used as travelling dispensaries along the Pahang (left) and Igan (right) rivers [Photographs: National Archives United Kingdom, 1937 (left), and Lau King Howe Hospital Memorial Museum, 2023 (right)]



TRAVELLING DISPENSARY BOAT ON PAHANG RIVER

Travelling Dispensaries

While the Sibu town folk could get treatment at Lau King Howe Hospital, those living in the remote interior had little access to medical care. Travelling Dispensaries, using native-style boats, were set up to meet this need. The first such boat was completed in Sibu in March 1948, and travelled along the Igan River providing simple treatment to rural folk. Travelling Dispensary No. 1 as it was known, was manned by a hospital assistant, an attendant and a boat driver. It did not only function as a mobile outpatient clinic, but also as a river ambulance to bring the very sick back to the dispensary or hospital. The staff attended to 3,792 patients in the first nine months of the mobile dispensary's operation and by 1949, the total attendances had increased to 13,893. More travelling dispensaries were set up and ten years later, there were four teams operating in the Third Division.



pawang), shophouses for traditional Chinese herbalists, floating boat dispensaries, mobile roadworthy dispensaries, and religious spaces, suggesting dispersion of the many variations of these facilities.²⁴ In Figure 2, two examples of water-based travelling boat dispensaries, extensions of the fishing-boat designs typical of the regions, illustrate how existing transport routes were utilised in West (left) and East Malaysia (right) to ensure remote communities received rudimentary care.

Although some of these medical outreach programmes in Malaysia and Singapore were eventually integrated into the colonial healthcare model, Ooi Giok Ling argues that colonial neglect encouraged greater reliance on Indigenous and ethnic medicines among migrants, a practice that persisted well into the twentieth century.²⁵ Each Indigenous and migrant community maintained its own herbalists, midwives, spiritual healers, and folk medicines, thereby sustaining Indigenous knowledge and ethnic practices. Colonial hospitals and European medical practices were feared as foreign environments that perpetuate alien practices. The diverse practices introduced complexities that challenged colonial healthcare ideals.

Reciprocal exchanges of medical practices are not discussed in scholarship on Sarawak; however, Richard Fidler argues for Chinese-Iban economic symbiosis in the Rejang Valley, whereby material goods were exchanged for jungle products.²⁶ The symbolic use of these imported goods such as iron, cloth, and jars in Iban rituals and ceremonies, and evidence of trade in “*rottan* [rattan], animal hides, *gutta percha*, camphor, rhinoceros horns, and monkey gall stones” for Chinese medicine, suggest forms of co-dependence which, the authors contend, prevented conflict.²⁷ A 1908 essay by A. E. Lawrence on spirit worship among Sarawak’s Milanau describes how images of the spirit believed to have caused the sickness are placed in model boats or houses and either floated down the river or consigned to the jungle as part of the Berayun ceremony.²⁸ In the case of an epidemic, a whole village might join together and build an elaborate sickness boat. Chinese medical practices accompanied migration. Kean Ghee Lim, in *The History of Medicine and Health in Malaysia*, mentions that a Fook Chow medical officer arrived in Sibuan as early as 1913, accompanying a wave of Chinese migrants and occupying a shack, which Lau King Howe Hospital (LKHH) eventually replaced.²⁹ Information on how inter-racial relations impacted Sarawak’s medical landscape is scarce.

Another important feature of East Malaysia was the close-knit internal riverine network, by which Indigenous settlements were identified in comparison to towns and *kampungs* in West Malaysia. Geography, rather than populous settlement patterns, assumed prominence in their histories. Sarawak is situated in the Samarahan and Sarawak river basins—the state capital, Kuching, is on the Sarawak River. Historically, including during the colonial period, the Iban were largely concentrated in the Batang Lupar, Saribas, and Rejang river systems, while the Land Dayaks were in the upper reaches of the Lundu, Sarawak, Kayang, and Sadong, notes Ooi.³⁰ The Melanau settlements were located in the lower reaches of the Igan, Oyah, Mukah, Balingan, Tatau, and Kemena rivers. Smaller groups were similarly distributed along the rivers’ various tributaries. These many groups practised either swidden wet-rice cultivation, with several inhabiting longhouses, while a few subsisted through hunting and foraging. As detailed by John Ting, the riverine system was the main transportation network fortified

at strategic points, used for colonial punitive expeditions, and for the circulation of commodities.³¹ The riverine and oceanic networks, which long preceded the construction of roads and highways, signal earlier geomorphic connections across Southeast Asia, between Borneo and Indonesia, and across the South China Sea.

Conversely, road-based connections between remote townships, cities, and capital cities can be understood as an urban phenomenon that replicates the networks between Sarawak, Peninsular Malaysia, and Singapore. During Singapore's independence, its pioneering medical schools were linked directly with Peninsular Malaysia via the University of Malaya's Kuala Lumpur division and by supplying trained staff to Sarawak General Hospital. Within the state, the network can be mapped through its roads and waterways, connecting smaller general hospitals throughout Sarawak to Sarawak General Hospital for specialist cases or referrals. Healthcare to remote areas is connected and delivered by travelling doctors and dispensaries by air and along rivers. These routes serve as conduits for mobility and economic growth, positioning the region as both centre and periphery within a medical network linking Singapore and Malaysia.

Institutional memories

Given these important differences between Peninsular and archipelagic Malaysia, and the scarcity of information on the medical histories of the latter, a possible entry point has been through institutional memories. Self-conscious reflection on colonial institutional legacies has been a postcolonial phenomenon occurring somewhat belatedly for hospitals, once their instrumental functions have been fulfilled. They are typically oriented towards research and training medical students through education into past practices, highlighting medical advances, whereby national imperatives absorbed or transformed colonial systems. Singapore's medical museums, established during and after the British colonial period, include the King Edward VII College of Medicine's Singapore Medical Museum (1905) and the Institute for Medical Research's Biomedical Museum (1983). Such collections, which featured anatomical specimens purely for educational purposes, can be seen as sites of affirmation for colonial authority and of scientific knowledge over Indigenous ways of healing.³² These institutions' initial focus on Indigenous bodies as hosts for tropical diseases established a racist foundation for colonial medical training. The display of biological specimens abstracted from non-European patients and used to represent their pathology objectified natives, dehumanising them as inferiors in the colonial medical system.³³ After independence, national governments in former colonies inherited and adapted colonial-built environments, administrative systems, and institutional cultures to serve local needs, though the degree of decolonising medical legacies varied. While demolition and expansion often erased evidence of spatial evolution, hospital museums preserved and reframed postcolonial developments in relation to colonial histories. In West Malaysia, hospital museums or medical museums commemorating hospital milestones and medical progress in the state emerged belatedly in 1996.³⁴ And although archival pamphlets describe the opening ceremony of Sarawak General Hospital Main Tower in 1970, featuring architectural plans and descriptions that highlight new, high-tech infrastructure, there is no equivalent museum in Kuching, the colonial nodal point in the hospital network.³⁵ East Malaysia's most prominent hospital museum is in

the neighbouring city of Sibu, a district in central Sarawak, at the former LKHH site. It is the first and only publicly accessible hospital museum in East Malaysia. The analysis of archival records, combined with the historical accounts gathered from the LKHHMM and notes from a guided one-on-one tour with a museum guide, suggests the complex dynamics between the Indigenous communities and the migrant Chinese community, and the new tensions that emerged from the creation of Malaysian identity in the state.

Section 2: Hospitals in Sarawak

Sarawak General Hospital

Sir James Brooke established Kuching, the capital and urban centre of Sarawak and a major port, in 1841.³⁶ Sarawak General Hospital was built just three decades later, in 1870, under the Brooke administration, to provide rudimentary health-care for this growing population.³⁷ It was the state's primary general hospital, and a key institutional node in this region's archipelagic network of colonial medical institutions, spanning Malaysia and Singapore. While Singapore was an administrative centre for British colonial rule of Malaya, Singapore, and North Borneo, the post-independence era saw a collective elevation and redistribution of administrative powers and resources throughout West Malaysia, Singapore, and East Malaysia. The establishment of several new hospitals within their network of medical institutions increased access to care for the broader population and reduced reliance on outstation healthcare support. In gaining independence from the British, regions such as Sarawak extended the reciprocal infrastructure connections between West Malaysia and Singapore.

Fig. 3 Top: The European Hospital and Dispensary was built in 1909 and was the first public building in Sarawak to be over two storeys high. It had a concrete frame supported by *bakau* (mangrove timber) piling. Bottom: The main entrance to Sarawak General Hospital in 1930 [Photographs: National Archives United Kingdom]



Once colonial general hospitals were repurposed as national institutions, the intended roles of existing migrant hospitals and medical practices changed. Before the British administration's duty of care extended to native and non-European communities, migrant hospitals were the preferred means of providing familiar and accessible healthcare to poorer populations. More evident in Sarawak, which had and continues to have wider Indigenous diversity and presence than in Peninsular Malaya, the persistence of 'ethnic' medical practices of non-European communities, including herbal and other remedies and midwifery extended to the many shamanic spiritual and ritualistic healing practices and ethnobotanical treatments of the Indigenous tribal communities spread throughout Sarawak. Colonial administrators and missionaries typically regarded these Indigenous practices as superstitious or unhygienic.³⁸ However, despite recognition of Indigenous diversity, the larger Dayak population remained the focus of research from 1946 to 1963.³⁹

Sarawak General Hospital, then known as Kuching General Hospital, first consisted of the European Hospital and the Pauper Hospital, with a mix of colonial and wooden, single-storey wards (Fig. 3). The European Hospital was

Fig. 4 Medical Headquarters, Sarawak, Kuching (1970). North-facing façade of the new hospital main tower [Photograph: National Archives United Kingdom]



situated near Chinatown and along Sarawak River before being consolidated and reconstructed to meet the growing region's training and capacity requirements.⁴⁰ While the European Hospital was an ornate colonial British Renaissance Revival building, the move inland along Jalan Tun Abang Haji Openg in 1925 allowed the hospital's architectural and medical presence to be reimagined and evolve alongside its contemporaries in Malaya and Singapore.⁴¹

When Malaysia was formed in 1964 through the alliance of these former colonies, Sarawak was included in the infrastructural upgrades proposed in the First, Second, and Third Malaysia Plans. This included the development of Sarawak General Hospital.⁴² The main tower of the new Sarawak General Hospital was proposed in 1969 and completed in 1970. Unlike the existing healthcare buildings of the time, this was the first medical facility in the state designed as a fully contained, air-conditioned, multistorey, multipurpose hospital building—exemplified by the hospital's Main Tower Block (Fig. 4).⁴³

Designed and planned in collaboration between the Public Works Department and Australian architects and engineers, Leighton, Irwin and Company, the key architectural elements included a fully equipped and contained nine-storey hospital block with full diagnostic facilities and wards.⁴⁴ Moreover, as the largest hospital in the state, Sarawak General Hospital provided medical services to all major towns and deployed remote medical services via travelling medical contingents.⁴⁵ However, as stated previously, while the hospital's technological innovation, training, and physical developments that are considered normative in the West are commemorated through in-house publications such as *100 Years: Sarawak General Hospital Kuching 1910–2010*, a hospital museum was not introduced at the time when similar facilities were being added to hospitals in Peninsular Malaysia. The only hospital museum comparable to those in Singapore and Kuala Lumpur was 400 kilometres distant in Sibu, a city in the central region of Sarawak, and the capital of Sibu District. Positioned at the confluence of the Rajang and Igan rivers, it is approximately 191 kilometres northeast of Kuching.

Lau King Howe Hospital, Sibü

Travelling from Kuching to Sibü in Malaysia takes a 40-minute flight or approximately five to six hours by bus or car via the Pan Borneo Highway, the main route connecting key Sarawak towns. Before the highway's construction, the longer, more winding journey used a combination of old trunk roads, ferries, and less-developed highways through farms and villages. While landlocked, Sibü was considered an important city outpost connecting townships in the hinterlands of Sarawak, many of which are connected to Sibü via the Rajang River.

Originally known as Maling, a small Melanau village in the 1850s, Sibü was part of the Sultanate of Brunei ceded to James Brooke in 1862. The Brooke Government built Fort Brooke that year, marking the official opening of Sibü town. The fort and many others in the riverine system were built to safeguard against attacks by the initially hostile Indigenous Dayak people. The town expanded with the arrival of migrant Hokkien Chinese workers from Fujian Province as early as the 1860s, who engaged in various economic activities, such as riverine shipping, trade, and brickmaking. While initially a fishing and farming village, the township eventually emerged as a commercial hub and, in 1873, became the base for the 3rd Division of Sarawak. In 1901, Fook Chow, Hin Hua, and Cantonese settlers arrived to pursue agricultural development, including the establishment of rubber plantations and rice farming.⁴⁶ The extensive tropical rainforest provided raw materials for processed timber, and the connectivity of rivers from the hinterland to the coast positioned Sibü as an ideal township for managing timber exports and shipbuilding.

The first hospital in Sibü, built in 1912 by the Rajah Brooke Government, was situated in front of the site of the old LKHH. It was "a wooden single-story raised-floor building about 50–60 feet long," reminiscent of the tiled pitched roof building type typically found in the tropics (Fig. 5). The hospital had an outpatient department and designated female and male inpatient wards. It was designed in a colonial architectural style typical of government buildings under

Fig. 5 Historical photograph of Lau King Howe Hospital [Photograph: Lau King Howe Hospital Memorial Museum]



the Brooke administration, featuring stilted, single-storey structures. When, in the early twentieth century, Sibu changed from a small village into a busy business town, and the original hospital proved too small for its growing population, Lau King Howe, a Chinese migrant based in Sibu between 1916 and 1930, donated his assets to the government to build a hospital. Influenced by his father's charitable work, he sought to benefit Sibu society and other similarly remote communities in the Sarawak hinterlands. The LKHH was established with his financial support in 1931 as Sibu's first general hospital and was connected to Sarawak General Hospital through staff training and patient referrals.

The LKHH exemplifies the efforts of private individuals in establishing community-oriented, migrant-built hospitals, which supported the influx of rural labour. Similar efforts are found throughout the region, most notably at Tan Tock Seng Hospital in Singapore and Tung Shin Hospital in Kuala Lumpur. The concluding section of this paper focuses on how the region's particularity is captured in its institutional memory.

Archipelagic memories

Sibu General Hospital replaced the LKHH in 1994, after which the latter was converted into a polyclinic and gradually closed as its services shifted to the new facility. From that time, members from the United Chinese Association Sibu Division, Sarawak Chinese Cultural Association, Sibu Chinese General Chamber of Commerce and Industry, Malaysian Medical Association Sibu Sub-branch, and Sibu Hotel & Tourism Association collaborated to establish the Memorial Museum, which opened in 1996 at the vacated campus as a tribute to the hospital and the memories shared by the Sibu community.⁴⁷ These memories took many forms related to the locality, including the building's spatial experience and its aesthetic character. Key architectural features of the main entrance, including the iconic hospital signage, the foyer entrance, and parts of the old building with tiled roofs, were preserved to house the museum. Although all the buildings on the old campus area were demolished and replaced by a commercial district, half of the original entrance building was retained.⁴⁸ While this space is now sealed and air conditioned, the vented blocks along the top of the walls remain. The former mortuary has also been preserved and converted into a lavatory.

Fig. 6 Examples of artefacts donated by former doctors, nurses, pharmacists, and administrators of Lau King Howe Hospital [Photographs: Catherine Mei Min Woo, 2023]



The former outpatient clinic, waiting area, pharmacy, and emergency department have been converted into a gallery displaying the hospital's significant medical artefacts and past achievements. Artefacts donated by doctors, nurses, pharmacists, and medical administrators who were previously stationed at the LKHH, have been conserved as nostalgic evocations of community memories and served as the narrative foundation for the exhibits that recount the hospital's history (Fig. 6).

Panels with textual descriptions and photographs represent the hospital's medical milestones, often accompanied by personal stories and anecdotes shared by the community. Exhibitions divided by medical speciality include the evolution of the Nursing Curriculum, tracing the development of Maternal and Child Health Services, a display of Old Nurses' Uniforms, Surgical Services, Old Dental Equipment, Intensive Care Services, and Obstetric Services. Additionally, a small section of the museum is dedicated to Lau King Howe and his legacy as a notable Fook Chow figure in the Sibu community.⁴⁹ A scaled model of the LKHH complements this section, offering insight into the scale of the hospital campus (Fig. 7).



Fig. 7 Scaled model of the old Lau King Howe Hospital campus, with the now-preserved main entrance in the foreground [Photograph: Catherine Mei Min Woo, 2023]



Fig. 8 The official Sibu guide distributed at local hotels, featuring the Lau King Howe Hospital Memorial Museum (in red) as a significant heritage museum and landmark [Pamphlet: P212 Pusat Khidmat Sibu, Sibu Service Centre]

While this museum honours the hospital and its milestones, it also serves as an educational hub, hosting students from kindergarten through to university and international visitors.⁵⁰ Other notable guests include former employees, visiting clan associations, interstate doctors, international travel groups, and members from medical societies. Unlike its Peninsular counterparts, the hospital museum is advertised in tourism pamphlets as a key institution within Sibu's tourism network (Fig. 8).

The description so far presents a predictable narrative of a community medical facility, albeit located in a remote area away from Sarawak's metropolitan centre. How, then, does this facility evoke its archipelagic context? This article argued that both Indigenous presence and the riverine geography differentiate East and West Malaysia. These particularities were conspicuously absent in Sarawak General Hospital, which was rationalised by Australian architects into a predictably modernist formalism, signifying medical science and sanitary, hygienic facilities. Its architecture, we might argue, could have been introduced to any Asian or even Western city. In fact, certain tropical architectural features, such as louvered windows, typically found in colonial hospital structures, were gradually phased out in favour of air conditioning.⁵¹

The LKHH offers a contrasting narrative. A 1986 account by two UK doctors of their elective period in Sarawak suggests the linkages between the LKHH and riverine dispensaries.⁵² “A single large hospital in Sarawak would have given a very restricted view of the country,” they note.⁵³ From their base at the 400-bed LKHH hospital, they travelled upriver to a smaller mission hospital at Kapit. Here, they joined a district health team visiting Iban villages in Song. Each longhouse, the largest of which could host 30 families, was visited every six weeks by dispensaries along the river, which travelled by boat. Two clinics were conducted at each longhouse, and their sanitary arrangements were inspected. Subsequently, the doctors were honoured with a feast and entertained.

Just as the river carried medical services to the remote districts and villages, it also brought patients to the city. A photograph among the LKHH exhibits of everyday life in Sibu during the flood season, with the elevated hospital entrance as its backdrop, upholds this relationship (Fig. 9). The narrative ignores the physical dysfunction of the city’s infrastructure in celebration of its symbiotic transformation by the river and the resultant range of social activities, including fishing from the hospital verandah. Remote Indigenous communities that used to walk to the hospital, or relied on travelling dispensaries, could instead opt for boat rides directly to the hospital entrance, making inundation advantageous rather than a hindrance to their mobility.

Fig. 9 Everyday life in Sibu during seasonal flooding at the front gates of the old Lau King Howe Hospital, ca. 1960–1970s [Photograph: Lau King Howe Memorial Museum]



Not only have these community experiences been included in the museum’s collective narrative and shared through the memories of on-site Indigenous curators and exhibits, they are also integral to its institutional memory. Its location at the original Melanau village site, with some 200,000 babies born in the hospital between 1936 and 1994, ties it firmly to the Sibu community—in fact, a fundraiser for “Babies of Lau King Howe,” to maintain the museum facility, was mooted in 2022.⁵⁴ But more importantly, the site’s adjacency to the river and memory of the annual flooding is incorporated into the museum’s design through the introduction of a pond as a permanent entrance feature (Fig. 10).

In navigating this feature, visitors are drawn into the archipelagic sensibilities of institutional memory outside the colonial nodal urban centres privileged in medical histories. Through research and observations, this article has recognised

Fig. 10 Present-day Lau King Howe Hospital Memorial Museum, with a man-made pond, installed in 2009 [Photograph: Catherine Mei Min Woo, 2023]



a notable shift in how Indigenous and migrant realities were willingly integrated by institutions unconstrained by colonial and developmental norms that emphasise biomedical progress. The multivocality of this museum's exhibits and celebration of unstable environmental conditions that would have been suppressed or managed elsewhere point to different experiential lenses and measures of success applied to archipelagic Malaysia's regional hospital designs.

NOTES

1. The article is based on Catherine Woo's archival research and fieldwork in London, United Kingdom, and Kuala Lumpur, West Malaysia, as well as in Kuching and Sibul, Sarawak. The research findings inform the article's comparison of hospital museums in these different cities. Anoma Pieris has aligned their interpretation with this journal's theme.
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