Who Inherits the Knowledge? Family Relationships, Trust, and Succession in Sangkal Putung Healing among the Malay-Javanese Community in Johor, Malaysia

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ABSTRACT

Traditional healing knowledge is sustained not only through the preservation of therapeutic techniques but also through social relationships that determine who is permitted to learn, practice, and eventually inherit such knowledge. This study examines the role of family relationships, kinship, trust, and succession in the intergenerational transmission of "Sangkal Putung", a traditional bone-healing practice maintained within Malay-Javanese communities in Johor, Malaysia. Adopting a qualitative ethnographic approach, data were collected through semi-structured interviews, field observation, field notes, and relevant documentary materials involving three purposively selected informants: one principal Sangkal Putung practitioner, one former patient, and one subject-matter expert. The data were analysed thematically to identify relational patterns surrounding the acquisition, restriction, transmission, and continuation of healing knowledge. The analysis is organized around four interconnected dimensions: healing knowledge as family heritage, trust as a condition of knowledge transmission, experiential learning through relational proximity, and the negotiation of future successors. The study argues that succession in traditional healing should not be understood as an automatic biological transfer from one generation to another. Rather, inheritance is a relational process in which kinship, personal character, commitment, practical participation, and recognition by senior knowledge holders collectively shape the legitimacy of a successor. The study contributes to family sociology, kinship studies, traditional knowledge research, and the safeguarding of intangible cultural heritage.

Keywords: family relationships; intergenerational transmission; kinship; Sangkal Putung; succession

INTRODUCTION

Traditional healing systems are sustained through more than the continued use of remedies, techniques, and therapeutic procedures. They also depend on social relationships that determine how knowledge is acquired, interpreted, protected, and passed to another person. In many local medical traditions, knowledge is learned through oral communication, observation, repeated participation, and close contact with senior practitioners rather than through formal curricula. This makes the family and kinship network analytically important because the household may operate simultaneously as a site of care, apprenticeship, memory, authority, and cultural reproduction.

Recent scholarship has increasingly recognised that intergenerational transmission is central to the continuity of living cultural practices. Ouma (2022) demonstrates that traditional medicinal knowledge is learned through place-based and relational processes and that migration and socio-spatial change can disrupt the ability of older practitioners to transmit knowledge to younger generations. In a different field of intangible cultural heritage, Igreja, Paúl, and Teles (2026) show that the family transmission of crafts is closely associated with intergenerational relationships, family cohesion, legacy, and the willingness of descendants to continue a practice. Together, these studies suggest that the continuity of traditional knowledge cannot be explained only by the existence of knowledge holders; it depends on the relational conditions under which knowledge is transferred.

The family is especially significant in traditional medicine because specialised knowledge is often selectively shared. In West Java, Febriyanti et al. (2024) found that family members constituted a major source of knowledge about traditional medicine, illustrating the continuing role of the family in health-related cultural

learning. Research in Ethiopia similarly reports that medicinal knowledge is frequently transmitted orally through family lines and may be restricted to selected relatives or trusted individuals (Awoke et al., 2025). Such patterns complicate a simple model of inheritance. Biological descent can establish proximity to the knowledge holder, but it does not necessarily guarantee that a child, grandchild, sibling, or other relative will become a recognised successor.

This distinction between biological relationship and recognised succession is important for understanding *Sangkal Putung*, a traditional bone-healing practice associated with Malay-Javanese communities in Johor. Existing research on traditional bone-setting in other settings has frequently concentrated on therapeutic processes, patient preferences, cultural beliefs, clinical risks, or the relationship between traditional and biomedical care. Tadesse and Kassaw (2025), however, demonstrate that traditional bone-setting knowledge may be acquired through familial transmission, apprenticeship, observation, and culturally sanctioned experience. Their findings indicate that bone-setting is not merely a technical skill; it is embedded within social relationships and systems of trust.

In the Malaysian context, traditional medicine is also strongly connected to inherited knowledge and cultural practice. Studies of Malay traditional medicine have documented locally grounded healing materials, rituals, and ethnographic practices, while also emphasising the importance of preserving knowledge that is vulnerable to social change (Jamian & Mohd Ghazali, 2021). Abdullah and Yunos (2024), in their systematic review of traditional medicine among Orang Asli communities in Malaysia, similarly highlight the restricted and family-linked circulation of traditional medical knowledge. These studies provide an important local foundation, yet the relational mechanisms that determine succession within a specific healing family remain insufficiently examined.

The present study therefore shifts the analytical emphasis from treatment technique to family relationship. Instead of asking primarily how *Sangkal Putung* treats fractures, the study asks how a healing tradition is socially reproduced through kinship, trust, participation, and succession. This shift is important because documentation alone does not ensure continuity. A treatment may be extensively described in writing, photographs, or recordings but still become discontinuous if there is no person who is accepted, prepared, and authorised to carry the knowledge forward.

The central research question is: How do family relationships and trust shape the intergenerational transmission and succession of *Sangkal Putung* healing knowledge among the Malay-Javanese community in Johor? Three subsidiary concerns guide the analysis: first, how family lineage contributes to the construction of healing identity; second, how trust and practical participation regulate access to specialised knowledge; and third, how practitioners and family members negotiate the selection, willingness, and legitimacy of future successors. The article advances the argument that *Sangkal Putung* knowledge is inherited relationally rather than merely biologically. Kinship creates a potential route of inheritance, but continuity depends on the quality of relationships, the commitment of the learner, accumulated practical experience, and recognition by the existing knowledge holder.

LITERATURE REVIEW

Family and Kinship as Channels of Traditional Knowledge

Family relations are among the most persistent channels through which culturally embedded knowledge is reproduced. The significance of the family lies not only in co-residence or biological connection but also in repeated interaction across time. Children and younger relatives may become familiar with a practice long before they receive formal explanations of it. They observe routines, hear narratives, accompany older relatives, perform minor tasks, and learn what kinds of behaviour are valued or prohibited. In this sense, knowledge transmission is inseparable from family socialisation.

The family-transmission literature is useful because it directs attention to continuity as a relational achievement. Igreja et al. (2026), studying artisans in a UNESCO Creative City, show that family-transmitted practices can strengthen intergenerational solidarity, shared identity, affective memory, and the sense of

carrying a legacy. Their study also demonstrates that continuity may remain uncertain even when a family values the practice, particularly when descendants select different occupational pathways. Although healing differs from craft production, the sociological principle is comparable: a living practice depends upon people who are willing and able to reproduce it within changing family circumstances.

Traditional medicinal knowledge offers particularly clear examples of this process. Ouma (2022) describes intergenerational learning as embedded in place, practice, and social relationships. Febriyanti et al. (2024) likewise show the importance of family sources in the circulation of traditional medicine knowledge in West Java. In Malaysia, Abdullah and Yunos (2024) note that traditional medical knowledge among Orang Asli communities may be restricted within families. These findings support treating kinship not as a demographic characteristic but as a structure that can organise access, obligation, identity, and responsibility.

Trust, Secrecy, and Selective Transmission

Knowledge that is socially valued is not necessarily distributed equally. Traditional healers may regard particular techniques, formulations, prayers, bodily skills, or diagnostic understandings as knowledge that requires discretion. Selective transmission can protect the reputation of a practice, preserve a family's authority, prevent perceived misuse, or ensure that the recipient has the personal qualities considered necessary to practise responsibly. This makes trust a central mechanism of succession.

Awoke et al. (2025) report that ancestral medicinal knowledge in their study area was transmitted primarily through oral communication within families, while some knowledge was shared with trusted relatives and neighbours. The finding is significant because it separates kinship from trust: family membership creates a social connection, but access to specialised knowledge may still depend on a judgement about reliability. Tadesse and Kassaw (2025) similarly show multiple pathways into bone-setting expertise, including familial inheritance, apprenticeship, observation, and culturally recognised experience. A useful implication is that a successor is socially produced through a process of evaluation rather than automatically generated by genealogy.

Secrecy should therefore not be interpreted only as resistance to documentation. In family-based knowledge systems, withholding and revealing information may be part of how authority is organised. A senior practitioner may disclose knowledge gradually as a learner demonstrates patience, discipline, ethical conduct, and commitment. From a family-relations perspective, the key analytical issue is not simply whether knowledge is secret but how trust is built, tested, and converted into permission to learn.

Experiential Learning, Tacit Knowledge, and Relational Proximity

Much healing knowledge is practical and embodied. It involves timing, touch, bodily judgement, interpretation of symptoms, interaction with patients, preparation of materials, and decisions that may be difficult to reduce to written instructions. For this reason, observation and participation can be as important as verbal teaching. Repeated proximity to a practitioner enables the learner to recognise patterns that may not be explicitly explained.

Ouma (2022) emphasises forms of intergenerational learning rooted in particular places and relationships. Tadesse and Kassaw (2025) similarly identify observation and apprenticeship as pathways through which bone-setting expertise is acquired. The succession process can therefore be conceptualised as a sequence of increasing participation: observation, assistance, supervised practice, correction, and eventual authorisation. Such a sequence also clarifies why living relationships remain important even when parts of a tradition have been documented.

For *Sangkal Putung*, this perspective directs attention to everyday family interactions surrounding the practice. A potential heir may first learn by being physically present, preparing materials, observing how the practitioner communicates with patients, listening to family narratives about earlier practitioners, or helping with non-specialised tasks. Over time, these interactions can convert family proximity into practical competence. The crucial point is that inheritance is a process, not a single moment of transfer.

Succession, Discontinuity, and the Safeguarding of Living Heritage

The problem of succession becomes visible when knowledge holders age but younger relatives are unavailable, uninterested, or considered unsuitable. Ouma (2022) identifies migration and socio-spatial transformation as forces that can weaken traditional learning arrangements. Igreja et al. (2026) also report difficulties in continuity when descendants disengage from family-transmitted craft practices. These studies show that the existence of descendants cannot be equated with the continuity of a practice.

This distinction is central to the safeguarding of intangible cultural heritage. The UNESCO Convention for the Safeguarding of the Intangible Cultural Heritage defines safeguarding broadly to include measures that support the viability and transmission of living heritage (UNESCO, 2003). Applied to traditional healing, safeguarding therefore involves more than recording knowledge. It also requires attention to the relationships, social recognition, practical learning opportunities, and intergenerational commitments that make future practice possible.

Within Malay intellectual traditions, traditional knowledge also forms part of a wider textual and cultural heritage. Muhammad (2025) demonstrates the breadth of traditional knowledge represented in Malay literary and manuscript traditions. Yet written repositories and living practice perform different functions. Texts can preserve descriptions, categories, and historical memory, whereas embodied practice requires people who can interpret and apply knowledge in context. The present study therefore conceptualises *Sangkal Putung* succession through four linked ideas: kinship provides proximity; trust regulates access; participation develops competence; and recognition establishes legitimate succession.

METHOD

Research Setting

The study was conducted in Sri Medan, Batu Pahat, Johor, Malaysia, within the social setting in which Sangkal Putung is practised and recognised. The research setting was treated not merely as a geographical location but as a relational environment in which healing knowledge, family memory, practical experience, and community recognition intersect. Sri Medan was retained as the specific locality for this article to ensure that the reported research site corresponds directly to the actual fieldwork.

> “Fieldwork was conducted from December 2024 to April 2025, covering an overall period of approximately five months. During this period, the researcher conducted interviews and field-based observation relevant to the practice and transmission of Sangkal Putung knowledge in Sri Medan, Batu Pahat.”

Participants and Sampling Strategy

Participants were selected using purposive sampling because the research question required individuals with direct knowledge of, experience with, or specialist understanding of Sangkal Putung. Three informants were included in this article: one principal Sangkal Putung practitioner who served as the key research figure and primary knowledge holder, one former patient with direct experience of the treatment, and one subject-matter expert with relevant knowledge of traditional healing practices. These categories were retained because each contributed a distinct perspective on the practice, experience, and continuity of Sangkal Putung.

Selection was guided by relevance to the study rather than statistical representativeness. The principal practitioner provided information on family inheritance, healing knowledge, religious interpretation, and succession; the former patient contributed an experiential perspective on treatment and practitioner legitimacy; and the subject-matter expert provided contextual and specialist interpretation of traditional healing knowledge. Individuals who were discussed by participants, including the practitioner's children, were not counted as separate study participants unless they were independently interviewed.

"The final sample for this article therefore comprised three informants (n = 3): one principal Sangkal Putung practitioner, one former patient, and one subject-matter expert."

Data Collection and Fieldwork Procedures

Data were collected through semi-structured interviews, field observation, field notes, and relevant documentary materials during the fieldwork period from December 2024 to April 2025. The interviews explored family lineage, the identity of earlier knowledge holders, pathways into learning, the role of family influence, trust, practical knowledge, willingness to continue the practice, and expectations regarding succession. Observation was used to contextualise the practice and the social environment in which Sangkal Putung knowledge was discussed and maintained.

Field notes were used to record contextual details, interactional observations, and researcher reflections that could not be captured adequately through interview accounts alone. Interview and observational materials were read together during analysis so that statements about family relationships, transmission, and succession could be interpreted within the wider field context rather than as isolated responses.

Data were collected through semi-structured interviews, audio recordings, field observations, and field notes during the fieldwork conducted from December 2024 to April 2025 in Sri Medan, Batu Pahat, Johor. The interviews were conducted primarily in Malay, with some use of Javanese expressions and vocabulary during communication with the practitioner. With the participant's consent, the interviews were audio-recorded as part of the research documentation. Field observations were conducted across approximately six to nine visits or observation sessions, depending on the circumstances of the treatment and the needs of the study. During these observations, attention was given to the treatment process, treatment practices, and elements associated with the patient's condition. The practitioner further explained that a course of treatment may extend over several weeks depending on the patient's condition, while an individual treatment session may last approximately one to three hours. The audio-recorded interviews were transcribed verbatim by the researcher. The transcripts were subsequently reviewed against the original recordings to ensure accuracy, while Javanese expressions were retained where relevant and interpreted within the context of the participants' accounts.

Thematic Analysis

The data were analysed using reflexive thematic analysis following Braun and Clarke's (2006) six-phase approach. First, interview transcripts and field notes were read repeatedly to develop familiarity with the data and to identify recurring relational episodes. Second, initial codes were generated around both explicit participant statements and observed processes relevant to the research question. These included family lineage, family identity, trust, secrecy, observation, assistance, apprenticeship, commitment, character, permission, recognition, succession, disinterest, occupational change, and concerns about continuity.

Third, related codes were grouped into candidate themes that captured broader patterns in the transmission process. Fourth, the candidate themes were reviewed against the coded extracts and the wider dataset to determine whether each theme represented a coherent and distinct relational pattern. Fifth, the themes were refined and defined in relation to the central distinction between biological inheritance and recognised succession. This process resulted in four analytical themes: (1) healing knowledge as family heritage; (2) trust before transmission; (3) learning through participation and relational proximity; and (4) negotiating the next successor. Sixth, the final analysis integrated ethnographic evidence with the relevant literature to explain how kinship, trust, participation, and recognition shape continuity.

Relationships were interpreted from the data through a combination of participants' descriptions of kinship and family roles, accounts of who was permitted to observe or assist, statements about whom the practitioner trusted, and evidence concerning who was regarded as capable or legitimate to continue the practice. This analytical procedure allowed the study to distinguish between being biologically related to a practitioner and being socially recognised as a successor.

Ethical Considerations and Confidentiality

Confidentiality was maintained by removing personal identifiers and referring to participants as Informant 1, Informant 2, and Informant 3 according to their roles in the study. This was particularly important because the article addresses family inheritance, selective knowledge transmission, and future succession. The manuscript reports relational information only to the extent necessary for analysis and does not identify the practitioner's children as participants because they were discussed within the practitioner's account rather than independently verified as interview participants.

Permission to conduct the study was obtained from the Department of Malay Language, Literature and Culture Studies, Faculty of Social Sciences and Humanities, Universiti Kebangsaan Malaysia. Permission was also obtained directly from the Sangkal Putung practitioner prior to the commencement of the fieldwork. The practitioner was informed of the purpose of the study, the nature of the data to be collected, and the intended academic use of the information obtained. Permission to conduct interviews, observe treatment-related activities, and make audio recordings for research documentation was obtained before data collection. Participant identities are anonymised in this article to maintain confidentiality.

Table 1. Participant Categories and Roles in Knowledge Transmission

Participant category	Number (n)	Relationship to practitioner	Role in transmission process	Evidence contributed
Principal Sangkal Putung practitioner / key research figure	1	Primary knowledge holder	Provides information on family inheritance, healing knowledge, religious interpretation, trust, and succession	Family lineage; inherited knowledge; family influence; succession expectations
Former patient	1	Patient / non-kin perspective	Provides direct experiential perspective on Sangkal Putung treatment and practitioner legitimacy	Treatment experience; trust in practitioner; community recognition
Subject-matter expert	1	Specialist / expert perspective	Provides specialist and contextual interpretation of traditional healing practice	Contextual interpretation; traditional healing knowledge; analytical triangulation

RESULTS AND DISCUSSION

The results are presented through four relational themes derived from the thematic analysis. The revised discussion incorporates verified information supplied from the fieldwork while distinguishing clearly between paraphrased participant accounts and verbatim quotations. Where an exact transcript quotation has not yet been supplied, the account is reported as a paraphrase and a highlighted author-verification note is retained so that an exact quotation can be inserted before resubmission.

Table 2. Thematic Framework for Family-Based Transmission of Sangkal Putung

Theme	Family-relational focus	Analytical claim	Field evidence to present
Healing knowledge as family heritage	Kinship, lineage, identity	Knowledge gains legitimacy through family history and remembered predecessors.	Genealogy, stories of parents/grandparents, family recognition.
Trust before transmission	Relational trust and gatekeeping	Biological relationship alone does not guarantee access to specialised	Statements on trust, character, secrecy,

		knowledge.	responsibility, permission.
Learning through participation	Intergenerational learning	Competence develops through observation, assistance, correction, and repeated proximity.	Accounts of following, helping, preparing, observing, supervised practice.
Negotiating the next successor	Succession and continuity	Continuity depends on willingness, suitability, opportunity, and recognition, not merely descendants.	Interest/disinterest of children, careers, migration, chosen heir, uncertainty.

Healing Knowledge as Family Heritage

The first theme positions *Sangkal Putung* knowledge as a form of family heritage rather than solely as an individual therapeutic skill. In family narratives, knowledge can acquire meaning through references to earlier practitioners, remembered acts of care, and the continuity of a name or reputation associated with healing. Such narratives transform technical knowledge into a family legacy: the practice becomes connected to who the family understands itself to be and to what earlier generations are remembered for contributing to the community.

This pattern is sociologically significant because lineage does more than identify the origin of knowledge. It can provide legitimacy. A practitioner who locates his or her knowledge within a recognised family history is not only describing where the skill came from; the practitioner is also locating current authority within a chain of relationships. This resembles findings from family-transmitted heritage practices in which inherited know-how, memory, and family recognition contribute to continuity and cohesion (Igreja et al., 2026). In traditional medicine, the same process may connect healing competence to obligations toward family reputation and community trust.

At the same time, family heritage should not be romanticised as an uninterrupted chain. The important analytical question is whether all descendants are treated as potential custodians or whether some family members occupy a closer relationship to the practice than others. The field data should therefore distinguish between genealogy as a narrative of origin and succession as an actual transfer of competence.

Ethnographic Evidence

The principal practitioner reported that his Sangkal Putung knowledge was inherited through his father, who had learned massage from his own mother, a traditional masseuse who had also served within the Johor Palace environment. The practitioner further explained that this inherited knowledge was complemented by Islamic religious knowledge, which he regarded as important for spiritual protection and for ensuring that healing-related practices remained consistent with Islamic faith rather than relying on paranormal knowledge considered contrary to religious belief. (Paraphrased account: Informant 1, principal practitioner, 2025).

The practitioner explained that his knowledge of Sangkal Putung was inherited through several generations of his family. His father acquired massage knowledge from the practitioner’s grandmother, who was known for her massage practice and had experience providing such services within the Johor royal palace environment. The practitioner subsequently complemented this inherited knowledge with Islamic religious teachings, particularly in relation to spiritual protection and ensuring that the practice remained consistent with Islamic belief.

> "I learned from my father. My father learned from his mother, my grandmother, who was really good at massage. My grandmother also served in the Johor Palace. I then add the inherited knowledge with religious knowledge so that the practices made do not contradict the faith and can protect oneself from disturbances."

(Informant 1, Sangkal Putung practitioner, 2025)

This account illustrates that the transmission of Sangkal Putung knowledge followed a multigenerational family pathway. The practitioner's account links healing authority to family lineage while also showing that inherited knowledge was not reproduced unchanged. Instead, it was interpreted and supplemented through Islamic religious knowledge. This indicates that intergenerational transmission involves both continuity and adaptation, whereby inherited practical knowledge is maintained while being reinterpreted according to the religious understanding of the current practitioner.

This account positions Sangkal Putung as both inherited family knowledge and a practice interpreted through a religious framework. The family line provides a narrative of legitimacy extending from grandmother to father and then to the present practitioner, while Islamic teaching functions as an additional moral and spiritual frame through which the practitioner evaluates acceptable healing knowledge. The finding therefore supports the argument that inheritance is not only a transfer of technique but also a transmission of family memory, authority, and values.

Family Influence, Interest, and Readiness for Knowledge Transmission

The second theme concerns trust as a gatekeeping mechanism. Family membership creates access to the everyday environment of the practitioner, but it does not necessarily confer entitlement to specialised knowledge. A potential successor may still be evaluated in terms of character, patience, responsibility, discretion, willingness to learn, and perceived ability to use the knowledge appropriately. This distinction is central to the article's argument because it shows that succession is socially negotiated.

Studies of traditional medicinal knowledge have documented selective sharing within family and trust networks. Awoke et al. (2025) found that knowledge was primarily passed within families while limited sharing occurred with trusted relatives and neighbours. Such evidence supports an interpretation of trust as a mechanism that regulates the boundary between general familiarity and authorised knowledge. For *Sangkal Putung*, the field material should be examined for language that signals this boundary: statements that knowledge cannot be given indiscriminately, that the learner must be observed first, or that moral and relational qualities matter before deeper instruction is provided.

Trust also has a temporal dimension. It is rarely created through a single declaration. It can be produced by repeated presence, reliability, assistance, and demonstrated commitment. Consequently, an heir may become legitimate gradually. A child who is biologically close but consistently absent from the practice may be less likely to inherit specialised knowledge than a relative who repeatedly assists and is recognised as dependable. This does not mean that non-kin automatically replace kin, but it reveals that the family line and the trust line are analytically distinct.

Ethnographic Evidence

The practitioner associated the development of interest and continuity with practical exposure and accumulated knowledge. He indicated that the influence of being exposed to the practice could encourage a younger generation to become interested in treatment activities, particularly when the practice was understood as a means of helping others and sharing inherited knowledge. (Paraphrased account: Informant 1, principal practitioner, 2025).

The field data indicate that family influence and repeated exposure to Sangkal Putung practice contributed to the development of interest among the practitioner's children. According to the practitioner, familiarity with the practice could encourage the younger generation to become interested in treatment, particularly when the practice was understood as a means of helping others and sharing inherited knowledge. The practitioner reported having nine children, three of whom had voluntarily demonstrated an interest in the practice. This finding suggests that biological descent alone does not ensure succession. Rather, voluntary interest and continued exposure to the family healing environment appear to distinguish those members of the younger generation who may become more closely involved in the transmission process. However, the present data do not establish a formal set of trust criteria or restrictions governing access to specialised knowledge.

Thank you for this important observation. Upon re-examining the field data, we found that the available evidence more directly supports family influence, repeated exposure, voluntary interest, and readiness to learn rather than a clearly articulated system of trust evaluation or restriction of specialised knowledge. We have therefore revised the relevant subsection to avoid overstating the evidence. The discussion now focuses on family influence, interest, and readiness for intergenerational transmission, while claims concerning explicit trust criteria and restricted knowledge have been moderated.

The available account suggests that sustained exposure to practice can create interest and relational familiarity, but it should not be overstated as evidence of formal gatekeeping unless the interview data explicitly show that the practitioner restricted knowledge or evaluated a learner's character before disclosure. In the final version, any stronger claim about trust should be tied directly to the practitioner's verified words.

Learning through Participation and Relational Proximity

The third theme explains how family proximity is converted into practical knowledge. The transmission of embodied healing skills is difficult to understand as a classroom-like process because much of the learning occurs through repeated exposure to practice. A prospective successor may begin by watching, accompanying the practitioner, preparing materials, helping to organise treatment, listening to explanations, or observing how decisions are made. Gradually, limited tasks may be entrusted to the learner.

This form of learning is consistent with Ouma's (2022) account of intergenerational traditional medicinal learning and with Tadesse and Kassaw's (2025) identification of observation and apprenticeship in the acquisition of bone-setting knowledge. The family setting can intensify this process because relational proximity increases opportunities for informal learning. The learner does not necessarily wait for a formal lesson; knowledge may be encountered during ordinary family life, visits by patients, preparation activities, conversations, and stories about previous cases.

Analytically, this suggests a progression from observation to participation and from participation to authorisation. The transition between these stages is important. Observing a practitioner does not mean that a person is recognised as capable of practising independently. A strong results section should therefore identify moments when the learner's role changed: when assistance was first requested, when a task was performed under supervision, when mistakes were corrected, or when the senior practitioner explicitly expressed confidence in the learner.

Experiential learning also helps explain why documentation cannot fully substitute for succession. Written descriptions can preserve valuable information, but tacit bodily judgements and relational knowledge may require guided practice. The social relationship between senior practitioner and learner therefore remains a core component of continuity.

Ethnographic Evidence

For analytical documentation, the study treats knowledge of treatment materials as more than a list of ingredients. The relevant chain of inquiry includes what materials are used, how they are obtained, who provides them, how they are processed, when and how they are applied, what function the practitioner attributes to them, and from whom the related knowledge was inherited. This structure strengthens the ethnomedical documentation of Sangkal Putung by linking materials to their practical and intergenerational context.

The field data indicate that the transmission of Sangkal Putung knowledge was associated with repeated exposure to the practice and familiarity with the treatment environment. However, the available interview and observation data do not document a sufficiently detailed sequential apprenticeship process involving clearly identifiable stages such as observation, assistance, correction, supervised practice, and progressively greater responsibility. Therefore, the present analysis does not claim a formal learning sequence. Instead, it interprets participation and exposure as important contextual conditions through which interest in the practice may develop.

Wan Aminah & Nik Norliza (2017) discussion, this finding may be discussed alongside previous research on Malay traditional medicine, which has shown that knowledge of medicinal materials and their uses is often transmitted through intergenerational inheritance and practical familiarity. However, such secondary evidence is used here only as a comparative point and not as a substitute for primary field evidence.

> Field-note extract: "During the treatment session, [describe only what was actually observed: who was present, what the learner did, what instruction/correction was given, and whether responsibility increased]."

(Field Notes, Sri Medan, Batu Pahat, January, 2025)

For this important clarification, we agree that the study by Wan Aminah Haji Hasbullah and Nik Norliza Nik Hassan (2017) constitutes secondary literature and cannot substitute for primary ethnographic evidence. We have therefore revised the subsection to distinguish clearly between field evidence and supporting literature. Where the field data do not document a complete sequential apprenticeship process, we have moderated the claim and no longer imply stages of observation, assistance, correction, and increased responsibility unless directly supported by the interview or field notes.

Secondary literature can be used in the Discussion to compare the Sangkal Putung findings with wider patterns of inherited herbal and practical knowledge, but the empirical claim about learning through participation must remain grounded in the present study's interviews or field notes. This distinction strengthens the analytical transparency of the article and prevents literature evidence from being presented as ethnographic evidence.

Negotiating the Next Successor: Continuity Is Not Guaranteed by Descent

The fourth theme addresses the uncertainty of succession. A family may contain descendants and still face a discontinuity in practice. Younger family members may pursue formal education, salaried employment, migration, or other professional identities; they may respect the family tradition without wishing to become practitioners. Conversely, a senior practitioner may hesitate to identify a successor because no available relative is considered sufficiently committed or suitable.

This problem has parallels in other family-transmitted cultural practices. Igreja et al. (2026) show that descendants' disengagement can create uncertainty about the continuity of a family legacy, even when the practice remains valued. Ouma (2022) similarly demonstrates how migration and changing socio-spatial conditions affect opportunities for intergenerational learning. In Malaysian traditional medicine, Abdullah and Yunos (2024) identify restricted family transmission as part of the vulnerability of local knowledge. These findings support the view that continuity is dependent on both structural opportunity and relational willingness.

For *Sangkal Putung*, the succession question should therefore be framed as a negotiation between the wishes of the knowledge holder, the interests of descendants, family expectations, perceived responsibility to the community, and the practical demands of contemporary life. This framing avoids treating younger generations as simply 'uninterested' and instead asks what conditions make continuation possible or unattractive.

The central finding to test against the field data is that the presence of a family line is not equivalent to the presence of a succession line. A viable successor requires relational recognition. If this interpretation is supported by the interviews, the contribution of the study is to show that the vulnerability of *Sangkal Putung* lies not only in the possible loss of techniques but in a break in the chain of relational transmission.

Ethnographic Evidence

The principal practitioner reported having nine children, of whom three had voluntarily shown interest and enthusiasm in the practice and treatment of Sangkal Putung. The account indicates that the existence of biological descendants does not automatically create a single succession pathway; rather, willingness and personal interest vary among members of the same generation. (Paraphrased account: Informant 1, principal practitioner, 2025).

The practitioner reported having nine children, three of whom had voluntarily shown interest and enthusiasm in learning and potentially continuing the Sangkal Putung practice. This suggests that biological descent alone does not automatically produce a successor, as only some members of the next generation demonstrated a willingness to become involved in the family healing tradition. This statement reinforces the distinction between biological inheritance and recognised succession. Although all nine children belong to the same family lineage, only three were identified as voluntarily interested in the practice. Succession therefore appears to depend not merely on kinship but also on willingness, interest, and continued engagement with the healing tradition. The manuscript has been revised to retain this finding as a paraphrased account unless the exact transcript wording can be verified. The revised text states that the practitioner has nine children, three of whom have voluntarily demonstrated interest in learning and potentially continuing the Sangkal Putung practice. We have avoided presenting this statement as a direct quotation unless it can be confirmed word for word from the recording or transcript.

This account provides direct support for the manuscript's distinction between biological inheritance and recognised succession. All nine children belong to the practitioner's family line, yet only three were described as voluntarily interested in the practice. The finding therefore suggests that descent creates the possibility of inheritance, whereas willingness, exposure, commitment, and subsequent recognition are more relevant to the emergence of a potential successor. Because the three children were not independently identified as study participants in the verified sample, their interests are reported only through the practitioner's account.

Relational Model of Sangkal Putung Succession

Across the four themes, succession can be represented as a relational sequence rather than a biological event. Kinship or sustained relational proximity creates access to the practice. Trust regulates the depth of knowledge that can be shared. Participation produces practical familiarity and competence. Recognition by the senior knowledge holder then converts competence into legitimate succession. The process can be interrupted at any stage: a relative may have proximity but no interest, a learner may have interest but insufficient trust, or a trusted assistant may never receive recognition as an independent practitioner.

This model provides a multidisciplinary bridge between family sociology, kinship studies, medical anthropology, and heritage research. It treats the family as an institution that can preserve knowledge but also as a gatekeeping structure that controls access. It also recognises that traditional healing knowledge is embedded in relationships of care, obligation, identity, and authority. Such an approach helps explain why safeguarding efforts that focus only on inventories, recordings, or written documentation may be incomplete if the social conditions of transmission are not addressed.

The model can also inform practical safeguarding. Documentation should be combined with opportunities for intergenerational learning, ethical recognition of knowledge holders, voluntary involvement of younger family members, and careful attention to consent and ownership. Any heritage initiative should avoid assuming that descendants have an obligation to become practitioners. Sustainable continuity requires both the protection of the practice and respect for the choices of family members.

CONCLUSION

This study reframes the continuity of *Sangkal Putung* as a problem of family relationship and succession rather than only a problem of treatment documentation. The analysis proposes that family lineage creates a potential pathway of inheritance, but lineage by itself does not produce a legitimate successor. Trust, practical participation, personal suitability, commitment, and recognition by senior knowledge holders mediate whether knowledge is transferred and whether a learner becomes authorised to carry the practice forward.

The article therefore challenges a simple parent-to-child model of traditional knowledge transmission. In a relational model, succession develops through repeated interaction. A potential heir may observe, assist, learn, be evaluated, and gradually receive greater responsibility. The family functions simultaneously as a site of cultural memory, practical learning, emotional attachment, authority, and gatekeeping. These roles help

explain why some knowledge can remain strong within a family for several generations while other knowledge becomes vulnerable even when descendants are present.

The study has practical implications for the safeguarding of traditional healing heritage. Preservation initiatives should not concentrate exclusively on documenting herbs, techniques, or treatment procedures. They should also recognise the social relationships through which knowledge becomes meaningful and usable. Programmes involving voluntary apprenticeships, family-based documentation, community archives, and ethical collaboration with practitioners may support continuity when designed with consent and respect for knowledge ownership.

The study is limited by the local and qualitative character of the evidence and should not be generalised to all Malay-Javanese families or all traditional healers in Malaysia. Family dynamics, gender, religious interpretation, economic conditions, and the organisation of healing authority may differ across households and localities. Future research should compare several practitioner families, examine gendered patterns of succession, and investigate cases in which knowledge is transferred beyond biological kin. Longitudinal research would also be valuable for tracing whether potential successors eventually become recognised practitioners.

Ultimately, the sustainability of *Sangkal Putung* depends not simply on whether the knowledge exists, but on whether relationships exist through which it can be responsibly learned, trusted, recognised, and continued. Understanding who inherits the knowledge therefore requires understanding the family relationships that make inheritance possible.

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