Conflicting Traditions, Concurrent Treatment: Medical Pluralism in Remote Aboriginal Australia

Eirik J Saethre
University of Pretoria

ABSTRACT

In remote Aboriginal communities in Australia, researchers cast health beliefs and treatments as belonging to either an Aboriginal or biomedical system, which are considered to be irreconcilable and in conflict. Warlpiri people also speak of two distinct traditions that, they claim, are able to heal only specific classes of illness. Nevertheless, both Aboriginal and biomedical systems can be used simultaneously. An examination of two illness episodes will illustrate the complexity of how both Aboriginal and biomedical diagnoses and treatments are employed in a similar manner. I argue that while diagnosis is often stressed in statements regarding illness, it is only one of many factors that influence the treatment choices of individuals.

Key words: Aboriginal Australia, health care, cosmological beliefs, illness behaviour

Aboriginal people suffer from significantly higher rates of mortality and morbidity than do non-Aboriginal residents of Australia. For the past several years there has been a gap of slightly less than twenty years between the life expectancy of Aboriginal and non-Aboriginal people in the Northern Territory (Department of Health and Community Services 2004:24). Aboriginal deaths from respiratory diseases are six times higher than non-Aboriginal deaths; from diabetes, eight times higher; from renal failure, eleven times higher; from homicide, six times higher; and from child infection, fifteen times higher (Territory Health Services 1996:21). Aboriginal Territorians have both a burden of disease (Zhao et al. 2004) and a hospitalisation rate (Department of Health and Community Services 2004:31) that is 2.5 times higher than that of non-Aboriginal Territorians. As a result, over half of the Northern Territory health budget is spent on Aboriginal people, who make up approximately one third of the population (Department of Health and Community Services 2004:35). What these statistics do not reflect is that Aboriginal people consider themselves vulnerable to a wide variety of diseases, some of which are not considered to be the domain of biomedicine, such as illness caused by sorcery.

In remote Aboriginal communities in Australia two healing traditions—Aboriginal and Western/biomedical—are often considered to exist. Researchers writing from the different perspectives of health care practitioners (Devanesen 1985; Gray 1979; Maher 1999), anthropologists (Mobbs 1991; Reid 1983), and political advocacy (Nathan and Leichleitner 1983; Saggars and Gray 1991) support this distinction. Despite the varying approaches employed by these authors to understand and propose methods of combating poor Aboriginal health, which range from encouraging greater rates of Aboriginal treatment at government clinics to arguing for independent Aboriginal health services, there is a general agreement that fundamental differences between Aboriginal and biomedical approaches to health exist. Each tradition is considered to have its own history, ethos, actiology, and treatment.
options. In many instances both Aboriginal healing beliefs and biomedicine are essentialised and reified, with much of the variation within both of these approaches being forgotten. For instance, biomedicine at Harvard Medical School is different from biomedicine in a remote area clinic in Central Australia. Likewise, there is a wide range of Aboriginal ideas regarding health and well being across the continent, making it difficult if not impossible to accurately simplify this complexity.

Nevertheless, many researchers attempt to typify the essential characteristics of both biomedicine and Aboriginal healing beliefs. The Aboriginal medical system is often cast as holistic, personal and social (Morgan et al. 1997:598; Nathan and Leichleitner 1983:91). It 'seeks to provide a meaningful explanation for illness and to respond to the personal, family and community issues surrounding illness' (Devanesen 1985:33). The link between health and social relations is often stressed (Devanesen 1985; Mobbs 1991; Morgan et al. 1997; Nathan and Leichleitner 1983; Reid 1983) and illness is characterised by 'social and spiritual dysfunction' (Maher 1999:230). In contrast, biomedicine is cast as 'particularistic, biophysical and mechanistic' (Nathan and Leichleitner 1983:91). Biomedicine is considered to view the body as a machine and illness as a malfunction of this machine (Fabrega and Silver 1973:218-223; Kirmayer 1988:57-60; Kleinman 1980:108). It is also common to portray the biomedical approach as casting disease as the result of physical and environmental factors, not social ones (Devanesen 1985:33; Morgan et al. 1997:589; Nathan and Leichleitner 1983:91).

Aboriginal and biomedical health systems are believed to be 'vastly different in philosophy and practice' (Nathan and Leichleitner 1983:72), and are compared in terms of a 'stark contrast' (Mobbs 1991:302) and a 'cultural gap' (Eastwell 1973:1012). 'Competing' (Nathan and Leichleitner 1983:70), 'poor compatibility' (Maher 1999:234) and 'clash' (Sutton 2005:1) are common ways of characterising the relationship between these two approaches. This cultural disparity is often considered to create barriers to effective clinical treatment. On one hand, the social environment of clinics is said to discourage some Aboriginal people from obtaining treatment (Mobbs 1991:314; Morgan et al. 1997:599), and indeed Aboriginal people can feel intimidated and uncomfortable in the biomedical setting of hospitals and clinics. On the other, Aboriginal beliefs in supernatural causes of disease are said to discourage Aboriginal people from presenting at the clinic for treatment for some illnesses. Tina, the nurse in charge of the clinic through much of my fieldwork said, 'Sometimes [Aboriginal people] think that they are suffering from sorcery so they don’t come in until their condition gets really bad. Then we have to evacuate them. If they would just come in earlier it would save us money and keep them alive longer.' As a result, researchers frequently discuss biomedicine’s poor social and cultural fit in traditional settings (Mobbs 1991; Public Accounts Committee 1996; Sagger and Gray 1991).

For decades, the assumed disparity between biomedical and Aboriginal health systems and its effect on health outcomes has been treated as a reality, motivating the introduction of programs aimed at integrating these perspectives. As early as the late 1970s, some health care professionals in the Northern Territory introduced the concept of ‘two way’ medicine. Ideally under a ‘two way’ approach, illness management continues to occur in the clinic, but patients would have the choice of consulting nurses, Aboriginal Health Workers, or Aboriginal healers and being prescribed pharmaceuticals or bush medicines. Devanesen (1985:36) claims that this approach bridges ‘the cultural chasm separating the traditional and western world views.’ 'Two way' medicine has come under criticism for favouring biomedicine and not adequately incorporating Aboriginal views (Burnett 1996:5; Humphrey, Dixon, and Marrawal 1998:100; Nathan and Leichleitner 1983:68; Sagger and Gray 1991:150). By the late 1990s, ‘two way’ medicine was largely deemed to be impossible to implement despite its intentions. In 1997, a nurse who had worked for fifteen years in Aboriginal community clinics remarked that ‘two way’ medicine had ‘never worked’ and expressed relief that the Northern Territory seemed to be moving away from its philosophy.
From 1996 to 2000, I spent twenty-six months conducting ethnographic research in a remote Warlpiri community in the Northern Territory. It has a population of approximately seven hundred inhabitants and like other remote Aboriginal communities in the Northern Territory, there is low labour force participation, many people are dependent upon government benefits, most homes are overcrowded and in disrepair, and nutritional health is poor. The first nurse arrived in the community five years after it was established—over fifty years ago—and found that nutrition was inadequate, scurvy was rampant, hookworm was spreading rapidly, 38% of the population had tuberculosis, and 32% had trachoma (Kettle 1991:73). It was another three years before a nurse was permanently assigned to the community but staffing problems continued to plague the clinic, which, during my fieldwork, had only two permanent positions for nurses. Although some of the health concerns have changed since the community was established, the Aboriginal residents continue to suffer from high rates of illness. To combat disease, residents have access to a wide range of healing options including medical staff, local healers, pharmaceuticals, and bush medicines. I was curious to know how and when each alternative was utilised.

Throughout the many interviews that I conducted, people echoed the views of much of the literature relating to Aboriginal health: there are two discreet systems. As I became more familiar with the community and its residents, I began recording illness episodes. Like others who had researched Aboriginal health (Beck 1985:84; Cawte 1974:43; Cutter 1976:38; Gray 1979:172; Skov 1994:20; Tonkinson 1982:229), I noticed that individuals used a variety of healing aids and technologies from both traditions. What struck me as important was not that Warlpiri people were able to use both systems but rather how they did so. Warlpiri people spoke of two different traditions, but in case after case, similar issues and concerns were at stake. Consequently, I believe that the assumption that biomedicine and Aboriginal healing beliefs are invariably conflicting and incompatible should be re-evaluated. I will demonstrate that there is a great degree of complexity in Warlpiri health behaviour that tends to be overlooked if simplistic and dichotomous models of health care systems are employed. First, though, it necessary to begin by reviewing how Warlpiri people in the community discuss the difference between Warlpiri and biomedical health traditions and their stated motivations for choosing a treatment from either of these medical systems. I will then examine two illness episodes as a means of contrasting the statements of individuals with the actions of individuals. Finally, I will return to the issue of how Aboriginal people can use what appear to be two very incompatible systems in a very complementary way.

**YAPA-KURLANGU AND KARDIYA-KURLANGU**

The division between biomedical and Aboriginal ideas about illness and healing is one that Aboriginal people themselves widely recognise (Maher 1999:234; Nathan and Leichleitner 1983:133; Reid 1983:134). Warlpiri people, from teenagers to the elderly, explicitly distinguish between two domains: *yapa-kurlangu* (belonging to Aboriginal people) and *kardiya-kurlangu* (belonging to white people). Individuals are able to class illnesses, and their causes, as belonging to either one of these groups. However, this division is not comprehensive and often relies upon a much more fundamental distinction: that between physical and spiritual illnesses. Spiritual illness is caused by the effect of a person’s soul—moving from its resting place in the solar plexus; having a foreign object, usually a sharpened piece of bone called a yarda, magically implanted in it; or being removed—on the body. Most spiritual illness is attributed to the intervention of ghosts or sorcerers, although fright or the breaking of customary law could also precipitate a spiritual illness. All spiritual illnesses are referred to as *yapa-kurlangu*. Audrey, 28 years old, explained, ‘Sometimes we get sick from magic. Kardiya don’t get sick this way; only yapa. It is *yapa-kurlangu.*’ Warlpiri people are aware that biomedicine fails to recognise spiritual illness. Liddy, 42 years old, said, ‘Those doctors, they don’t understand Aboriginal sickness. They do x-rays but they still can’t see that bone inside.’
In contrast, physical illnesses only affect the body. For instance, broken bones, infectious disease and diabetes are considered to be caused by natural events such as accidents, viruses, and high blood sugar. The most prevalent physical illness in the community is *mintja*, which occurs when the balance between hot and cold in the body is lost. *Minta* was often described to me as being similar to a cold or flu. Warlpiri people believe *mintja* may be caused by a variety of natural events, such as contact with an infected person, lack of food, cold weather, or bad hygiene. While the causes of *mintja* may vary from case to case, the common curatives remain the same: resting, consuming liquids, keeping warm and using medicines. Whereas *mintja*, and many other physical illnesses—for instance a fracture obtained while riding a bicycle—are not labelled as either *yapa-kurlangu* or *kardiya-kurlangu*, those that are thought to have resulted from contact and colonisation are considered ‘white’ illnesses. Diabetes is widely recognised as one such disease throughout the Northern Territory, its cause being attributed to the consumption of ‘white’ food such as processed sugar (Humphrey et al. 1998; Saethre 2005; Scrimgeour et al. 1997). As Alan, 50 years old, explained, ‘We say that diabetes is from *kardiya* because we didn’t get sick like that before they came.’ Warlpiri people acknowledge that both Aboriginal and non-Aboriginal people suffer from physical illnesses. If I was ill, I was repeatedly told that I was suffering from *mintja*, because, many people told me, I was *kardiya* and couldn’t get a spiritual illness.

Warlpiri people attend the clinic to obtain treatment for physical illnesses. Although a doctor did make fortnightly visits and Aboriginal Health Workers also occasionally staffed the clinic, it was the non-Aboriginal nurses who treated the majority of people. Treatment occurred at the clinic, which was open from 8am to 4:30pm during the week but the nurses were required to be on call twenty-four hours a day for emergencies. Over a six-month period the nurses treated an average of forty-seven people a day and on some days over eighty people presented, which is over ten percent of the community’s population. Patients were usually examined in a large central room, although they could request a private room if needed. The nurses generally spent only a short time with each patient. The clinic logbook records that over seventy percent of all consultations last fifteen minutes or less. Nursing staff reported that bandaging minor cuts and injuries, treating infectious diseases, managing chronic disease, giving injections, and distributing pharmaceutical drugs occupied most of their day in the clinic. These services are provided free but residents could also choose to purchase health aids from the local shop including paracetamol, cough syrup, antibiotic ointment, antiseptic cream, decongestants, and laxatives. The clinic as well as the pills and injections that it distributes are considered *kardiya-kurlangu*. Ted, 20 years old, said, ‘All of that medicine, that is *kardiya-kurlangu*.‘

*Kardiya-kurlangu*, though, does not hold a monopoly on pharmacopoeia to treat physical illnesses. Bush medicines, usually consisting of plant materials or animal fat, are considered to be *yapa-kurlangu* and are used to heal a variety of conditions. Most herbs are used to treat specific symptom such as coughs, wounds and sores. Every adult, and many children, have some knowledge of bush medicines. When I fell ill, I was regularly told which bush medicine would provide the best relief for my symptoms. Most bush medicines are either rubbed directly on the skin or inhaled, usually after being boiled in water. Less than ten percent of medicinal plants are taken internally, unlike biomedical healing aids (Latz 1995:61). Compared to pharmaceuticals, bush medicines are more highly regarded. Steve, 37 years old, said, ‘Nothing is better than bush medicine for a cold. You take all of those pills from the shop and nothing happens but after using bush medicine you get better.’ Foods that would have been collected in the bush and consumed prior to contact, such as kangaroo, are also believed to generally improve health. Subsisting on a diet of these foods is viewed by many as an effective way to treat illnesses that result from eating ‘white’ food, such as diabetes. Residents have justified non-compliance with diabetes medication by vowing to eat a diet of bush medicines, which, they say, is both healthier and more effective (Saethre 2005). Other Warlpiri healing techniques are also praised, when compared to their biomedical equivalent. James, 16 years old, suffered a severe burn on his leg.
and said, 'Yapa way is best—go down to the creek, put some cool mud on the burn and then let the air go around it. Putting a plaster on it doesn’t let the air heal it. That is why I don’t go to the clinic.'

While there are a variety of ways to heal a physical illness, it is only by obtaining treatment from a ngangkari, an Aboriginal healer, that a spiritual illness can be cured. Ngangkari do not treat physical illness nor do they distribute bush medicines. In the community, ngangkari are almost invariably male but can be of any age. They are not trained or registered and do not have a special status within the community. Ngangkari obtain their ability to heal through the possession of a magical healing substance, nguwa, which resides in their solar plexus. During an examination, the ngangkari inserts his nguwa into the patient’s body, where it is able to locate any magical pathogens that might be injuring the patient’s soul and remove them. Consulting a ngangkari is a common occurrence that can take place almost anywhere—in homes, at football matches, at card games, during a ceremonie, or inside automobiles—and at any time. Most people have family members who are ngangkari and will generally consult these people more regularly than other ngangkari, who will often expect payment for their services. Ngangkari are considered yapa-kurlangu and often contrasted with medical practitioners. Jessica, 54 years old, said, 'You kardiya have doctors, but we yapa have ngangkari.'

Aboriginal people in the community say that they choose a treatment based upon the cause of a disease because each practitioner is only able to treat one class of illness. If the disease is caused by natural factors then they might go to the clinic or collect bush medicines but if the illness is caused by sorcery, they must consult a ngangkari. Bill, 33 years old, said, 'Maybe if you have minta those nurses can make you right. But there are some things that they can’t fix. You have to be sure which one you have.' A diabetic man in his forties said, ‘Ngangkari can’t cure my sickness. I have to go to the clinic.’ On the other hand, those suffering from sorcery will not be aided by the clinic. James said, ‘You gotta get out that bone. Nothing else, no needle, no pills, will make you better.’ If treatment is obtained from medical practitioners, it can be deemed to be ineffective if the true cause of the illness is thought to be spiritual. For instance, when Betty, an elderly community member, returned from a heart operation, she said, ‘Those kardiya doctors, they couldn’t see really. They told me to have that operation but it didn’t help me. I still had those yarda.’ Listening to these statements gives the impression that Warlpiri people follow a clearly demarcated and unambiguous treatment regimen depending on the cause of the illness: biomedical for physical illness and Aboriginal healers for spiritual illness. No one in the community has ever told me that it was a combination of ngangkari and biomedical intervention that ended their illness.

If this is the case, then diagnosis and aetiological beliefs become two very important issues in determining treatment. A belief that an illness is caused by sorcery could delay or even prohibit a visit to the clinic, which, if the illness were serious, could lead to death. Hence, some people, such as nurses like Tina, see the belief in sorcery to be fundamentally detrimental to the clinical care of Aboriginal people. This view seems to be based on two assumptions. The first is that Aboriginal and biomedical systems are mutually exclusive. Employing the diagnoses and therapies of one automatically precludes the use of the other. The second assumption is that it is diagnosis that largely determines illness behaviour. Given the statements of health professionals and Aboriginal people these two assumptions may at first appear reasonable. However, they are based primarily upon the statements of Aboriginal people and not their actions. Nathan and Leichleiter (1983:132) state, ‘What has been recorded is what people said occurs and not what may happen in actual practice. Nevertheless, it is a sociological truism that beliefs dictate actions.’ To critically evaluate the preceding assumptions, I will illustrate how generalised statements can differ from actual behaviour by examining two illness episodes that occurred simultaneously and lasted for an extended period.
GEORGE

At the time of his illness, George was 44 years old, married and had four children. Although he considered himself to be healthy, George was obese, suffered from hypertension, seldom engaged in any physical activities, and would complain of feeling ill as many as three times a month. Nevertheless, George seldom went to the clinic for treatment. One day George began experiencing a low fever, sore joints, stomach cramps, and lethargy. He confessed that initially he was sure he was suffering from a bad case of *mintaka*. George attempted to end his illness by resting in bed, drinking plenty of liquids, and taking paracetamol to reduce his fever. He said that he would have preferred to use bush medicines as well because, ‘They will fix you up quick. They are a lot better than pills because they don’t have side effects.’ However, George stated that he did not have the time to leave to gather the plants.

After three days passed and his health continued to decline, George said, ‘When it didn’t go away I thought that maybe I should see a *ngangkari* and he told me that I had a *yarda*.’ After the *yarda* was removed and two days of rest, George reported that his fever subsided and the symptoms began to lessen. But only four days later the same symptoms returned. George concluded that either the *ngangkari* was ineffective or that he had contracted *mintaka* as a result of being weak following the removal of the *yarda*. To determine which diagnosis was correct, he consulted another *ngangkari*, who found and removed a *yarda*, confirming George’s suspicion that he was still suffering from spiritual illness. Over the next several days, George’s symptoms worsened and he began consulting *ngangkari* on a regular basis, two of whom were his sons, and had pathogens, including *yarda*, a dilly bag, and snakes, repeatedly removed from his body. On a single day, George had ten *yarda* removed by three different *ngangkari*. His general lack of improvement did not discourage him from seeking further care. He said, ‘I am sick *yapa* way. Only strong *ngangkari* man can cure me. That is our culture, our way.’

When asked about the cause of the sorcery, George claimed that it was clearly a strong sorcerer and not a ghost because otherwise the *yarda* would not keep returning. He said he did not know the identity of the sorcerer but assumed that it was someone who was angry with him because of his powerful position within the community. Another opinion was given by Larry, who at 56 years old was considered a senior man in the community. Larry blamed George’s illness on a contravention of customary law. He stated that when George was visiting another community, he spent the night in the same home as his mother-in-law. In many Aboriginal communities, a son-in-law cannot speak to, touch, or make eye contact with his mother-in-law (Mobbs 1991:318). Larry believed that the ghost of George’s father-in-law ensorcelled George as a result of this breach. Based on his diagnosis, Larry stated, ‘He needs to find a real *ngangkari*. That is the only person that can make him [good].’ When I asked him about consulting the clinic he replied, ‘Those sisters won’t be able to help him. They are rubbish when we have *yapa* sickness.’ Nevertheless, as George’s health worsened, his wife and daughter pressured him to attend the clinic for an examination. His wife, Margaret, was adamant that the treatment provided by the *ngangkari* was ineffective. She said, ‘Sometimes *ngangkari* are [good] but not now. He thinks it is *yarda* but it isn’t. Probably there is something wrong with his organs, and those sisters could find out.’ Despite their insistence, George repeatedly resisted consulting the nurses saying, ‘The sisters can’t do anything to make me [good]. I have a spiritual illness.’

Although George did not want to attend the clinic, he did request a variety of healing aids from me: vitamins, extra-strength pain relievers, and antibiotics. George was in the habit of taking vitamin C tablets sporadically when he was suffering from *mintaka*. George was clear that his current illness was related to sorcery, but he still asked for vitamins. Furthermore, George had been taking a steady supply of paracetamol since the beginning of the illness but he said that it was doing little good. He was eager to obtain prescription-strength
pain relievers like those that he had been given by a temporary male nurse several months earlier. Finally, George requested antibiotics. He said, ‘I am swollen. Those antibiotics will make all the water in my body come out so I can breathe.’ I explained that the nursing staff would not honour my requests for either pain medication or antibiotics until they examined him, but even though he looked quite bloated and felt miserable, George refused to go to the clinic, saying, ‘That sister might [yell at] me. It would be shame job.’ One nurse in particular, Tina, was said to be aggressive towards Aboriginal people and was referred to as ‘cheeky’ by many community residents.

By the fourteenth day, George was unable to walk without assistance and too ill to leave his home, where he continued to receive treatment from ngangkari. Three days later, George agreed to attend the clinic but only after first consulting a ngangkari, who could remove any yarda in case he was evacuated to the hospital in town where this type of treatment would be difficult to receive. George was unable to locate an available ngangkari and decided go directly to the clinic. When he arrived, the nurses immediately took his blood pressure. It was 218/196. George later told me that he did not understand what these numbers meant. While removing the apparatus Tina said in a brisk voice, ‘You are really sick. Do you understand? You should have come in sooner.’ Without another word she left George to talk with Dorothy, the other nurse on duty, and arrange a plane to fly him to hospital for treatment. With George resting in another room, the nurses explained to me that George was suffering from severe oedema, probably retaining up to ten litres of extra fluid, which was the result of congestive heart failure. Causes of heart failure include high blood pressure, obesity, and lack of exercise, all of which applied to George. Both nurses said that they had spoken to him earlier regarding his non-compliance with medication for hypertension. Tina recalled, ‘I told him months ago to take his medicine but he refused. I knew this would happen but what can you do? We can’t force it down their throats.’ Tina believed that given his behaviour and the severity of his condition, he would live for less than five years, a prediction that proved accurate.

As the nurses chatted together in another room, Warlpiri people sitting beside George began to discuss, in Warlpiri, his symptoms. After a while a consensus emerged, with which George’s wife and daughter both agreed: the fatigue, water retention, and nausea was caused not by heart failure but by a snake that had been recently removed from George’s body by a ngangkari. The pain he was still experiencing was probably just a residual effect of the snake. Although a few people wanted George to be checked for any additional signs of sorcery, most believed that his symptoms would disappear in time without further assistance. Jack, a 35 year-old, commented that George would be able to travel to hospital knowing that the cause had been eliminated, thus ensuring a complete recovery: ‘That snake was taken out. You will be good now.’ Even though the cause of the illness was removed, no one suggested that George refrain from travelling to hospital for treatment.

**SARAH**

At the time of her illness episode, Sarah was 33 years old and had two children. As a child, she had rheumatic heart disease and consequently was prone to bouts of ill health. She was prescribed antibiotics, mostly penicillin prophylaxis, regularly until she was twenty-three. Sarah was diagnosed with a heart murmur at the age of twenty-four. Initially, doctors chose not to give her a prosthetic valve due to her itinerary. They felt that she might abandon the compulsory medication thus causing her to stroke. She contracted Hepatitis C at the age of twenty-nine and consequently has an enlarged liver. The next year Sarah had a mitral valve replacement and two years after that, at the age of thirty-two, she was hospitalised with pneumonia.

When Sarah’s illness began, she reported feeling tired with aches all over her body and began taking paracetamol to treat the symptoms. Initially she assumed that it was physio-
logical. Sarah had a history of medical problems and, like George, episodes of ill health were not unusual. Sarah said that she was accustomed to visiting the clinic and stated that she often reported there if she was unsure of her health status. Sarah was also urged to go to the clinic by her mother, Deborah. Deborah said, 'It is important for yapu to go to the clinic early. Otherwise, their illness can get a lot worse. Late presentation is a big issue that we face.' Deborah had been an Aboriginal Health Worker for twelve years, most of which were spent working at the community clinic. If Deborah was working in the clinic, she reported that she would often attend to Sarah’s needs if her daughter presented for a consultation. During this illness episode, however, Deborah was employed by the Women’s Centre.

Sarah was diagnosed with systemic lupus erythematosus (SLE), a chronic inflammatory autoimmune disease that may, depending upon the individual case, be difficult to comprehensively treat. Initially, Sarah acknowledged that her illness was physical and agreed that the medical staff of the clinic were best equipped to treat her effectively. The nurses tried to control her symptoms with medication but Sarah reported that this did little good. Consequently, Sarah repeatedly consulted the clinic, sometimes as often as every other day. Sarah began to change her diagnosis when, one night in a dream, she saw her ex-father-in-law Virgil paying a senior man to ensorcell her. Sorcery is solely the domain of men, and some older men are believed to be particularly powerful. Deborah claimed to have had the same dream, thereby confirming Sarah’s diagnosis. Sarah believed that Virgil was trying to kill her because eleven months earlier her husband became drunk and severely beat her and her two children. While she was still in hospital recovering, Sarah reported that Virgil threatened her life if she had his son arrested. Sarah claimed that she told the police not to prosecute but nevertheless Virgil’s son was sentenced to several years in prison. After having the dream, Sarah said that she immediately began consulting ngangkari. Like George, she consulted several ngangkari, but it was a close classificatory brother who treated her the most.

Initially, even though Sarah was being treated by ngangkari, she continued to present at the clinic. Her frequent consultations and repeated requests for aid in combating symptoms that were difficult to comprehensively and effectively treat eventually led the nurses to become frustrated with Sarah. After a couple of weeks passed, the nurses felt Sarah was occupying an unreasonable amount of their time. During one consultation Tina told Sarah, ‘Every time you come in here I tell you the same thing. There is nothing more we can do. Now you take up our time and we can’t help other people that are waiting.’ After three weeks Sarah stopped going to the clinic. When asked why, Sarah replied that she had realised that she was suffering from a spiritual disease, not a physical one. She said, ‘I don’t need to go to the clinic anymore because I know now what the real cause of my sickness is.’ Nevertheless, Sarah said that she still continued to take the pills given to her by the clinic on a sporadic basis as well as non-prescription medication, primarily paracetamol, which she purchased at the shop. After seeing ngangkari for two weeks and not recovering, Sarah decided to move to her outstation in an attempt to escape the sorcery of the men in the community. After four months she moved to another community, where she resided for two years.

As with George’s illness, I also discussed Sarah’s diagnosis with Larry. He disagreed with Sarah’s notion that she was ensorcelled by Virgil. Unlike his explanation of George’s illness, Larry did not blame Sarah’s condition on sorcery or spiritual factors. He said that Sarah was suffering from heart disease inherited from her mother. Larry explained, ‘Her genes are bad. That is why she is sick. It is her mother’s fault because she gave rubbish genes.’ The discussion quickly shifted to Deborah, who, Larry commented, has ‘turned her back on the community.’ Larry stated that as a health worker Deborah had done a good job, but two years earlier she left the clinic to work at the Women’s Centre. Larry said that by resigning at the clinic Deborah was ‘causing trouble.’ He asserted that people expected her to help the community in the health centre since she was qualified as a health worker. Larry
replied, ‘I don’t know why she left the clinic. She said stress but that is a rubbish excuse. She needs to go back.’ When I reminded him of Sarah’s illness he replied, ‘Sorcery isn’t right. She shouldn’t be seeing ngangkari all the time. She won’t get better that way. The doctors need to look at her heart again. She should be in hospital in town, not in [the community].’

**DIAGNOSES AND TREATMENTS**

The examples of George and Sarah’s illnesses demonstrate how Warlpiri people are able to simultaneously utilise diagnoses, health care practitioners, and pharmacopoeia that are considered to be both Aboriginal and biomedical. Initially, it might appear that George and Sarah went about treating their respective illnesses in different ways, one choosing what some would consider to be an Aboriginal approach, the other a biomedical one. Although different methods might appear to have been used, there are similar patterns of treatment seeking behaviour in both instances. For example, in each case social norms surrounding gender play a role. Gender divisions exist throughout a wide range of Warlpiri activities, ceremonies, and locations (Dussart 2000; Meggitt 1962). Neither gender wishes to participate in activities or visit locations that are the domain of the other. Gender also plays a role in some personal interactions as can be seen in the case of mother-in-law avoidance. If a breach occurs, the individual will often describe it as shameful, a concept which is much more severe than the English word suggests. Gender norms can influence attitudes and behaviours concerning a wide range of activities, as was the case with George and Sarah.

Sorcery accusations often reflect social norms, realities, and tensions within an Aboriginal community (Berndt 1964:265; Berndt 1982:134; Cawte 1974:39; Reid 1983:87; Sagers and Gray 1991:51; Taylor 1977:36). Three of the diagnoses that occurred during these episodes are examples of how illness explanations can echo social concerns. George was said to have fallen ill as a result of staying in the same home as his mother-in-law—a breach of normative proscriptions. Sarah’s accusation of sorcery against her father-in-law highlights tensions between men and women in the community that resulted from domestic violence. Larry’s statement regarding Sarah’s illness also articulates these social tensions: Deborah quit the clinic to work at the Women’s Centre, thereby depriving the men of her expertise in a clinical setting. Larry blames George’s illness on the intervention of a ghost; Sarah attributes her illness to a sorcerer; while Larry claims Sarah’s sickness is the result of genetics. While sorcery can be a useful way to link illness and social experience, so can biomedicine. By disagreeing with Sarah’s explanation, Larry chose to blame Deborah, via genetics, for Sarah’s illness instead of Victor or other males in the community. Using a biomedical explanation that casts Deborah, a woman, as the cause, Larry is able to absolve both himself and other older men from blame. While Sarah’s explanation of sorcery casts the men as responsible for her illness, Larry’s explanation of genetics implicates another woman. Consequently, biomedical justifications are capable of being used and manipulated to disclose and comment upon social tensions in a way similar to sorcery accusations.

Gender concerns play a role in not only diagnosis, but also in treatment. Both George and Sarah initially consulted health practitioners that were the same gender as themselves. George began by visiting ngangkari, who were all male. In addition to receiving treatment from them, he asked me, also a male, to obtain a variety of pharmaceuticals for him. Sarah, on the other hand, consulted nurses, all of whom were female. Because of the gender divisions in biomedicine, almost all of the nursing staff in the community are female. The presence of female nurses does not act as a social barrier for Aboriginal women and they consequently regularly consult the clinic. As a result, the clinic is considered a largely female space. Over a two-year period, only one of the twelve nurses that staffed the clinic was male. George only told me of one previous visit to the clinic and that was made to consult the male nurse who prescribed the extra strength pain relievers that he would later ask me to
procure for him. Men tend to avoid the clinic, claiming that to go there would cause them shame, as George did.15 Often male patients will not present for treatment unless it is their last resort. Over two-thirds of the charts in the community clinic are for women. While late presentation might be justified in terms of the division between physical and spiritual illness, George’s desire for pharmacopoeia indicated that he was not rejecting biomedical technology or kardiya-kurlangu per se. Rather, he was hesitant to attend a clinic where he could be shamed, and later was, as a result of being confronted and scolded by younger white women.

Both George and Sarah also chose their initial treatment from people with whom they were familiar. For instance, of the ten ngangkari that George consulted, two were his actual sons, one was his close classificatory grandfather, three were close classificatory brothers, four others were senior men that had close ties to him through ceremony, and only one was unknown to him, a visitor from Arnhem Land. Many people in the community base their opinion of a ngangkari solely on their relationship with that person. Howard, 28 years old, said, ‘I don’t believe in ngangkari. They are all fake, except my uncle. He is a real ngangkari.’ Elsewhere in Australia both Gray (1979:180) and Willis (1985:27) note that Aboriginal patients initially prefer to consult ngangkari to whom they are related or in whom they have confidence. When George initially requested prescription medication, he did so from me, someone who he had known and spent time with for over a year. Likewise, Sarah had a personal connection with the clinic. Even though her mother was no longer an Aboriginal Health Worker, Sarah was used to the clinic environment and the people that worked there. Because of her regular consultations, a nurse who had been in the community longer could introduce Sarah to a newly-arrived nurse thus gaining a rapport. The importance of having a personal knowledge or connection of treatment providers to health seeking behaviour among Aboriginal people is well known. For instance, a desire to encourage personal connections with the clinic and thereby raise consultation rates acted both in part as a motivation and objective for the Aboriginal Health Worker program (Devanesen 1982:21; Josif and Elderton 1992:11; Willis 1985:31) as well as prompting concern over the high turn over of nursing staff in the Northern Territory (Cramer 1995:23; Public Accounts Committee 1996:52; Tatz 1972:17).

Regardless of whether or not the clinic was initially consulted, George and Sarah both took a variety of biomedical drugs for the duration of each of their illness episodes. While George attributed his illness to sorcery, he regularly took paracetamol and requested antibiotics. Even when healthy, George consumed paracetamol so often that he always kept a pack in his pocket. Sarah was prescribed medication by the clinic and even after she began consulting ngangkari, she continued to take the pills sporadically, as well as paracetamol. Many of the residents in the community are accustomed to taking pills when they feel ill. In the community, there are two primary locations though which medications can be obtained: the shop and the clinic. The former requires money and the latter requires interacting with the nurses, both of which can act as barriers to obtaining medications. I spoke to three men who would send their wives to collect their medications from the clinic because, as one of them put it, ‘There are too many [women] there.’ Some residents regularly requested pharmaceuticals, causing the nurses to dub them ‘script queens’. One nurse reported that because so many people requested paracetamol and other non-prescription pharmaceuticals from the clinic, its budget ballooned, forcing the staff to stop distributing medications that could be purchased at the shop. After being turned away from the clinic because she only claimed to be suffering from a headache, Maisy said, ‘The sister won’t give me pills. She says I have to buy them from the shop. But I won’t get my money until next week.’ Both George’s and Sarah’s continued use of medications shows that the barrier to the consumption of drugs can lie either with income or access to nursing staff but not with aetiology or even the disposition of the health practitioner that is being consulted.

Despite their continued use of medication throughout their illness episodes, both
George and Sarah had a previous history of non-compliance. Unfortunately, non-compliance often leads to serious health problems, as was the case with George. Both George and Sarah told me that because they did not feel ‘sick,’ they could not see any benefit to taking the pills at the rate prescribed by the nursing staff. George also said that he was concerned about the health risks of taking medication for extended periods. Nurses reported that non-compliance is relatively common in the community, particularly among those suffering from chronic diseases. Martin, a 32 year old diabetic, said, ‘[The nurses] said I am really sick, but I don’t feel anything.’ Noticeable symptoms were one of the main reasons Aboriginal people in the Northern Territory sought help in controlling diabetes (Scrimgeour et al. 1997:45). London and Guthridge (1998:727) believe that non-compliance among diabetics is not due to ‘simply a lack of bio-medical knowledge.’ The personal experience of illness greatly influences the rate at which medications are consumed. Elizabeth, 42 years old, also did not comply with her diabetes medication but did take vitamin C tablets every day because she claimed that they empirically prevented boils. Pharmaceuticals and vitamins, like bush medicines, were taken to treat specific noticeable symptoms and if these symptoms were not present then pharmacopoeia was not regularly consumed regardless of the instructions of the nursing staff. The illness episodes of George and Sarah illustrate that it is not just access to medication but also the experience of illness that can influence the way in which pharmaceuticals are consumed.

Despite having symptoms, neither George nor Sarah took any bush medicines during their illness episodes. Very few people in the community consumed bush medicines on a regular basis when ill. Among a sample of Aboriginal residents older than 50, 76% reported familiarity with bush medicines but less than 2% had taken bush medicines in the two weeks prior to the survey compared to 56% who reported taking prescribed medicines during this period (Sevo 2003:305-325). Only twenty-four percent of Aboriginal people surveyed in the region reported utilising bush medicine once within a six month period (Aboriginal and Torres Strait Islander Commission 1994:22). This was despite the overwhelming endorsement of the efficacy of yapara healing aids, including bush medicines. James, who extolled the virtues of placing mud on a burn, made this statement with a large dressing on his leg that was obtained at the clinic. Bush medicines are not used more frequently, in part, because they are much more difficult to obtain than pills (Saggers and Gray 1991:56). There is no place in the community where medicinal plants can be bought and gathering them can be time consuming and requires transportation as well as money for petrol. Although in the past the clinic occasionally stocked bush medicines as part of a ‘two way’ approach, this had not occurred for several years. However, the lack of use does not imply that Aboriginal people doubt the effectiveness of bush medicines (Scarlett et al. 1982:169). Consequently, the infrequent use of bush medicines can often be attributed to convenience rather than a distrust of the efficacy of these therapies.

STATEMENTS AND ACTIONS

While extended illnesses such as those experienced by George and Sarah are not unique, neither are they the norm. The majority of illnesses in the community are brief and usually receive little treatment, if any at all, before symptoms disappear. In these cases, diagnosis and treatment can be much more unambiguous and static. As illness episodes lengthen, people generally begin to use a wider range of therapies and diagnoses. The experiences of George and Sarah are able to illustrate a few of the ways in which Warlpiri people seek treatment, but this is by no means an exhaustive list. Social dynamics, symptom type, and resource availability are all variables that can change from illness to illness and as a result, so can responses to illness. For instance, is a trusted ngangkari visiting another community that week, has a relative recently started working at the clinic, has the family’s fortnightly
income been depleted? Consequently, while it is possible to ground an analysis in past illness episodes, it is impossible to construct a hierarchy of resort that every Warlpiri person follows when ill. My goal in describing the illnesses of George and Sarah is not to plot a prognostic cultural roadmap, but rather to examine how individuals utilise aetiology and therapies that are commonly referred to as conflicting and discrete traditions during a single illness episode.

Because of the number of treatments that are employed in many extended illness episodes, it is possible to choose from a variety of diagnoses and attribute recovery to either yapa-kurlangu or kardiya-kurlangu. Some diagnoses, and as a result claims regarding the efficacy of a specific therapy, are capable of expressing ideas regarding social relationships within the community, as Larry's comments demonstrate. Therefore, statements about the ultimate cause and cure of an illness need not necessarily act only as a roadmap to treatment, but may also be a social tool or method through which events can be meaningfully interpreted. As a result, publicly blaming a disease on sorcery does not inevitably exclude the possibly of clinical treatment. Likewise, clinical treatment does not necessarily lead to the rejecting of sorcery as a cause or attributing recovery to ngangkari. Throughout Australia, local Aboriginal therapies can be credited with precipitating healing even though biomedical facilities were also utilised (Elkin 1994:160; Meggitt 1962:389; Mobbs 1991:316; Tonkinson 1982:239; Willis 1985:28). Some researchers suggest that the lack of biomedical knowledge possessed by many Aboriginal people leads them to resort to local explanations, with which they are more familiar, even though clinical treatment is used (Taylor 1977:39; Tonkinson 1982:239). As George's initial examination demonstrated, it is possible for patients to be given very little meaningful data regarding their illness.

Statements claiming that diagnosis alone motivates treatment overlook other factors such as social concerns, familiarity, experience, and convenience that also play a role in treatment seeking behaviour. George's desire to avoid being shamed at the clinic influenced his refusal to consult the nurses more than a belief that biomedical technology could not treat him effectively, as his requests for pharmaceuticals demonstrate. In this instance, it was social factors that helped to encourage his continued reliance on ngangkari. Another motivating factor was the experience of illness. Both George and Sarah consulted a wider range of health practitioners as their illness continued. George agreed to go to the clinic after becoming seriously ill and Sarah did not begin consulting ngangkari until after weeks of clinical treatment proved ineffective. Likewise, noticeable symptoms acted as motivation to consume pharmaceuticals or bush medicines in a way that the instructions of nursing staff did not. Social norms and the experience of illness are just two of many factors that can motivate therapy choices to transcend the bounds of an initial diagnosis.

Because the diagnosis of an illness episode can shift and does not solely influence treatment seeking, local aetiological beliefs should not be viewed as invariably detrimental to the adoption of biomedical therapies. Warlpiri beliefs concerning the division of spiritual and physical illnesses do influence how disease is explained, and may even act as justification to delay a trip to the clinic, but do not automatically exclude the possibility of employing clinical explanations or treatment. Furthermore, a lack of biomedical explanation does not necessarily imply either a lack of faith in the efficacy of the clinic or a rejection of biomedical treatment. For instance, although both Betty and George stated that their illness was spiritual, neither refused hospitalisation or medical care when it was offered. Consequently, when Warlpiri people assert their belief in either sorcery or the division of spiritual and physical illnesses, it is dangerous to invariably assume that this is the only factor that discourages clinic attendance. Other factors, such as social norms and experience of illness, will probably have a greater influence on the choice of therapy. As one medical researcher in the community noted, 'I had a feeling that [Warlpiri people] had a great respect for some of the domains of Western medicine but their social context refrained them from exploiting them.'
Issues such as gender, familiarity, convenience, and experience all play important roles in the treatment of illness regardless of the medical system individuals chose to employ. Theoretical aetiological models, both biomedical and Warlpiri, might be used to make sense of a disease and to justify behaviour but individual responses to a particular illness are capable of transcending the prescribed treatment of these models. Although Warlpiri people tend to portray the treatment for specific illnesses as relatively rigid and predictable, their behaviour is not. Individuals approach health individually, at specific moments and in specific circumstances. Ngangkari, nurses, pharmaceuticals and bush medicines can be used as options that may or may not be the most comfortable, accessible, socially acceptable, or expedient way to end disease. Based on a purely theoretical understanding of philosophies and treatment regimens, it might seem reasonable to assert that biomedicine and Aboriginal health conceptions and therapies are very different. However, from the perspective of sick individuals, this is not necessarily the case. Warlpiri people are capable of situating both traditions within a local context.

When examining Warlpiri health-seeking behaviour in the community it is important not to rely solely upon 'sociological truisms' which tend to 'compare societies not in terms of empirical realities but in terms of reified concepts' (Jackson 1989:11). Instead, the lived experience and actions of individuals should be considered. Every illness episode is unique and consequently responses to illness can vary. There is no cultural roadmap that is universally followed in every instance. The interplay of factors such experience, gender, familiarity and income ensure that there is no fast link between diagnosis, treatment, and adherence to that treatment. Devitt (1998:87) accurately observes, 'Patients may both subscribe to preternormal causality and adhere—to the best of their ability—to medical treatment; also they may not.'

CONCLUSION

Warlpiri and biomedical traditions do have dissimilar histories, philosophies, aetiologies, and treatments, yet Aboriginal people are able to concurrently utilise aetiologies and technologies from both. Nevertheless, there remains a persistent trend of reifying and essentialising Aboriginal and biomedical traditions and casting them as fundamentally incompatible. Not only does this perspective tend to ignore much of the complexity that occurs in health behaviour, it can have serious consequences for health interventions. If treatment is believed to be chosen based on contrasting and conflicting theoretical and notional ideas regarding health, it might seem reasonable to implement programs that exclusively promote a information-based approach to improving health behaviour; for instance, replacing Aboriginal cosmological beliefs with biomedical education. However, initiatives focusing completely on inculcating knowledge of disease from a biomedical perspective run the risk of ignoring other factors that also influence treatment choice.

Responses to health care are also affected when assumptions of conflicting Aboriginal and biomedical traditions are employed as a political tool expressing and validating ideas of ethnic difference. Notions of 'holistic' Aboriginal health traditions and 'mechanistic' biomedical protocols can be used to portray the former as beneficial and the latter as a means of domination. Flick and Nelson (1994:4) write, 'Using western scientific methodology and demanding rigorous empirical evidence of benefit, as defined within this scientific approach, is a continuation of the patronising practice of imposition.' The key to better health, it seems, is to repudiate colonial tendencies in favour of Aboriginal means and technologies. As Aboriginal health transformed into a political issue, it has motivated calls for self-determination, land rights, and Aboriginal empowerment rather than biomedical interventions. So as not to 'blame the victim' some health practitioners avoid explanations attributing high rates of disease to the agency of Aboriginal people (Kowal and Paradies 2005).
Anthropologists such as Sutton (2005) have argued against the over-politicisation of health interventions by suggesting that behavioural change is necessary if Aboriginal well being is to be improved. As this paper demonstrates, altering some health seeking actions, such as attending the clinic earlier or complying with medication, could potentially lead to better health outcomes. However, behavioural explanations can also lend themselves to embodying concepts of ethnic difference at the expense of medical comprehensiveness. Throughout the 1990s a great deal of social science and medical research examining HIV/AIDS in Africa focused on ‘African’ culture, which was thought to be characterised by promiscuity, gender inequality, and aberrant sexual practices (Gausset 2001). Epidemiological cofactors that influence the transmission of the disease such as access to health care, poverty, malnutrition, and parasite load were largely overlooked when compared to behavioural explanations (Stillwaggon 2003:811).

Whether praising or criticising indigenous traditions, views that dichotomise illness beliefs and technologies appear to be more useful as expressions of social ideas than medical ones. While local conceptions of health do influence how illness is conceived and treated, they should not be automatically reduced to a single or rigid Aboriginal system that is contrasted with biomedicine. Such a propensity tends to ignore the lived realities that many Warlpiri people must deal with on a daily basis including poverty, social obligations, gender concerns, and the experience of illness. It is these issues that must be meaningfully understood and addressed if Aboriginal health is to be improved.

NOTES
1. All names used are pseudonyms.
2. Cawte (1964:978) describes three Warlpiri classes of illness: organic, traditional, and assimilation. Organic illnesses are caused by natural events such as cold weather. Traditional illnesses are caused by sorcery, and assimilation illness, such as diabetes, are a result of colonialism.
3. The concept of ‘white’ illnesses is found elsewhere in rural Aboriginal Australia (Beck 1985:84; Nathan and Leichleitner 1983:134; Reid 1983:134; Sagers and Gray 1991:57; Willis 1985:28).
4. Latz (1995:62) has recorded over seventy plant species as being utilised for healing purposes, one third of which can be found in the Acacia or Eremophila genus.
5. For instance, Euphorbias and Sarcostemma are rubbed on sores and burns through Central Australia (Devanesen and Hershall 1982:163). In contrast, juju minyumuyi (Pterocaulon spheclatum), is prepared in hot water and the steam inhaled to clear congestion.
6. Females are also responsible for the health of the community through the use of songs, the yawalyu, which can be sung for specific complaints such as swelling, soreness, pain or a fever, as well as to promote the entire health of the community. However, yawalyu songs are not able to remove the effects of sorcery. For more information concerning yawalyu see Bell (1982), Devanesen (1985), Dussart (2000), Mann (1973), and Peile (1997).
8. The choice of treatment options based upon the diagnosis of spiritual or physical causes is described elsewhere (Gray 1979:172; Nathan and Leichleitner 1983:138; Tonkinson 1982:239).
9. As a result I could not find well documented evidence of his health history.
10. Angales (1996:120) reports 651 out of every one thousand Aboriginal people have rheumatic heart disease. This figure is high compared to other groups such as Hawaiian/Samoan (206/1,000), Sri Lankan (142/1,000) and Maori (125/1,000).
11. For Warlipiri people dreams may often reveal the cause of sickness. This is particularly true if sorcery is involved. Anthropologists have documented similar beliefs throughout the Western Desert (Dussart 2000:148; Elkin 1994:40; Peile 1997:116; Porrier 2005; Tonkinson 1982:232).
14. SLE patients in the United States, Canada, and the United Kingdom also used alternative medical therapies at higher rates than those without the disease (Moore et al. 2000).
REFERENCES


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