CHAPTER 8

Traditions of Medicine and the Miracle of Modernity

When the mission first came, the elders were displeased because they refused to give us the medicine that would bring cargo.

KAIYA, 1980

Though the missionaries prayed and promised the conversion of the Maring, searching heaven and earth for signs that their message was taking root, they were also and painfully aware that the locals seemed less interested in the Good News than in God’s power as revealed in the hospital and trade store. For Maring, the desire for Western medicine was inseparable from the appropriation of the wellspring of the power of encompassing agents and institutions. Like tales of imported wealth and the affair of money, it was part of their attempt to capture new and more compelling sources of the production of value. As ancestors were instrumental in the vitality of pigs and produce, so the combined forces of the Holy Trinity would furnish the medicine for health and wealth. In the beginning, as the epigram underlines, the Maring drew no distinction between technical and ritual action, between spiritual and medical and economic realities, and accordingly they entertained that mission and medicine were blood brothers in the construction of Western power, political, economic, and otherwise. The next quarter century would attempt to teach the Maring about Western visions and divisions of body and society.

Finding the nature of indigenous medicine obscure, convinced it was a talisman of the primitive in the process, both the mission and the state envisioned the provision of Western medicine as a touchstone of modernity—as a domain of life in which they had a clear and overwhelming advantage. While the abstract nature of God and state might elude the Maring, nothing was more real than the body, nothing more miraculous than returning those on the cusp of death to good health. For the missionaries, the body embodied the communion of spirit, substance, and sociality. It was the temple of the to-be-redeemed soul. An earthly site where the power of Christian faith was as visible “as sunlight after rain” and the portals of conversion ever more open. Though there was never a bull or even

246
a whisper from Canterbury on the virtues of medicine, on the frontier healing had the glow of a secular sacrament. But no less for being so. The premise, accepted as beyond question, was that biomedicine was the epitome and exemplar of Western ascendance. Its practical power showcased all of the virtues, verities, and authority of the Western mind. While people might imagine familial life, farming practices, education, and patterns of speech as matters of habit and habitat, no one could fail to grasp biomedicine as objectively superior to all other pretenders. Its virtues and advantages were not situational or a matter of personal perspective. They were inscribed in the body itself—in nature rather than culture. And in the recognition that beneath the social self there was a biological individual, a God-made container for the human soul. The Christian spirit and the desire for improvement could find its deepest roots only in a body that was sound and sentient. Both the soldiers of the Savior and the state would convert the Maring to modernity by healing and health care. As Christian leaders of all stripes would attest, it was Jesus himself who anointed medicine as a privileged site and testimony to the power of the Almighty. Certainly, the story of Jesus awakening Lazarus from the dead was a winning sermon, a crowd-pleaser that made a lot more local sense than walking on water or transforming it into a better beverage. So nowhere did the West mark and map its project of modernity more than in the field of medicine; nowhere did it encompass and subsume Others with greater peace of mind.

The insertion of a formalized Western medical system into the practical state of ethnomedicine ignited a set of transformations that began in local curing practices but rapidly, inevitably diffused throughout the social tissue. Vernacular visions and examples of the ordinary person who reclaimed the normalcy of health through the supranormal use of magic and spells transport us to the center of Melanesian images of power and potency as well as the ordinary practices whose enactment and values anchored the social. Thus the confluence of Western biomedicine and Maring ethnomedicine could not but bring to the fore all the issues surrounding the generation of generations, the forging of subjectivity, and the foundations of the power and authority to inflect collective action. As this suggests, the encounter between the two medicines unfolds across numerous planes at once, planes that imbricate and communicate through the bodies and acts of embodiment of those concerned. At the most immediate, the encounter materializes as the social history of medical practice, the character, trajectory, and stages of its evolution since contact. This encapsulates questions of change in the indigenous perception of accident and illness, the evaluation of healing, the goals of treatment, the terms of integration of the two medicines, and the emergence of medicine as a quasi-autonomous field. These questions have more reaching implications because the transfer of medical control from shamans to health personnel
was a transformation in the locus of power. It reconfigured the relationship between the Maring and the mission/state, between generations, and invariably between men and women in that control over the body—which is inseparable from control over the processes of embodiment and personation—was at stake. Not only were these areas of transformation interrelated—Western medicine, the state, and Christianity arriving hand in hand—but the concepts that permeated biomedicine seeped into other practices. The Maring increasingly cited them as evidence and argument in village court cases, used them to divine Christ’s interpretation of community behavior, and deployed them in the strategies and struggles of everyday politics. Because ethnomedicine and curing were not part of a restricted field of knowledge or desire, the advent of biomedicine would influence everything from religion to epistemology. In this respect, the confluence of bio- and ethnomedicine walked the same path as the genesis of scientific medicine in the West (see Porter 1992).

As always on the frontier, these transformations lie at the crossroads of the relationship between the objective structures of the two medicines and the cognitive and motivating structures that animate social action and sociality. Because these processes conjoin, as though by an unintended act of cultural summation, the dividual and individual dimensions of the person in respect to two medicines and three generations, analysis can be reduced to a single perspective (ecological, demographic, etc.) only at the cost of a serious loss of reality. First, each medicine has its own objective structure—structures that, differently designed, presume entirely different stances toward sociality and the body, and thus instill and presuppose their own forms of knowledge, disposition, and desire. But also, what “patients” believe and sense through the agency of their own body as a dimension of the social body influences the outcome of treatment and hence the efficacy ascribed to that intervention. For these reasons alone, no theory that assumes that biomedicine progressively replaces ethnomedicine because of its “objective” efficacy will ever suffice. The perspective adopted here, which is no more than an acknowledgment of the ethnography, is that the advance of Western medicine reshaped local attitudes and dispositions toward the use and usefulness of medicine, and also that indigenous attitudes and dispositions, as embedded in practice, inflected the circulation of biomedicine into the Maring region. Meaning and value lie at this intersection. It is thus essential to inquire both how the advent of Western health care was reshaping ethnomedicine (i.e., people’s behavior, sensitivity, and practices) and how this determinate appearance of biomedicine under the auspices of the Anglican mission was inseparable from, because mutually determined by, ethnomedicine. Both the indigenous vision of medicine and the specific agents who delivered biomedicine
to the Maring doorstep were midwives to the incorporation of Western science into local lifeways.

Another way of approaching these issues is to ask how analysis can grasp the meaning and functions of ethnomedical practice. How to interpret and account for the determinate shape of illness and cure, the symbolic and pragmatic functions that accrue to them, and the effectiveness of healing rituals? These are all concerns that have appeared in the Melanesian literature, and in italics with respect to the Maring. On this ground, I maintain that understanding ethnomedical practices is not a question of recovering their ecological, biopsychological, and/or physiological effects, but of restoring their practical necessity. In the context of modernity, this means that ethnography must come to terms with the significance and functions that people, embraced in an ongoing encounter with the West, confer on medical practice and experiences, given the protean forms of knowledge and desire that configure their conceptions of health and illness. Sometimes overdetermined, sometimes underdetermined, these practices and experiences are always immersed into a river of signification spiked with political intent. This alone should remind us that no transcultural vision of health care as a means to insure the well-being of individuals can even begin to explain indigenous curing. Nor can it explain Western medicine in either its domestic or exported appearance, which, however much it ideologizes itself as the objective and instrumentally driven diagnosis and treatment of the biological individual, has its own economy and politics of the body. Western medical practice seeks to commoditize a service for individual consumption, thus bracketing the social conditions for the production of illness and recovery even as the research community accumulates evidence demonstrating their organic linkage (that work-related stress promotes cancer, that AIDS patients who join supporting communities have a longer life expectancy and improved chances of remission, etc.). The result is that the meeting of medicines involves a triangulation, an interplay between the scientific field of medicine, Western medical practice, and ethnomedicine. This creates medical encounters of the third kind for Westerners as well as Melanesians: even as Western medical practitioners shun ethnomedicine as primitive witch-doctoring, medical investigation has been discovering some of its benefits that, through the rear door reserved for the exotic, are entering into the medical consciousness of Westerners.

What does this tell us? First, without understanding the character and use of ethnomedicine, it becomes impossible to grasp the product of the historical encounter. Western medicine no more simply replaces ethnomedicine than Christianity simply replaces indigenous spirituality. Second, scarcely more insight derives from analyses that, in the tradition of
the ethnography of folk medicine, ignore the biomedical conditions against which agents shape and evaluate indigenous knowledge and practices. This folk viewpoint cannot shed light on the vulnerabilities of ethnomedicine that are evident to its own practitioners or, what amounts to the same thing, on the indigenous notions of efficacy in play when the encounter occurred. Finally, Western conceptions of health and medical practices are themselves a historically unstable mixture of research and ideology. So what was exported to the Maring and Melanesia was an arbitrary confluence, defined by the state and delivered through kiaps, missionaries, and medical personnel. Only by dissecting, at the field hospital so to speak, the body of the two medicines can we recover the dialectic of encompassment.

Medicine in any context, and profoundly in the fields of encompassment, underlines the relationship between social epistemology and the body of persons. How do concepts of the body become inscribed in the body? And how does the inscription of the body in the world—which involves the mediated mediation between nature, the objective structures of sociality (always critically, the cultural construction of nature), and the embodied forms of knowledge, desire, and dispositions—shape the construction of the subject? How does the body as organic, the flesh and bone subject to death and decay, challenge the cultural construction of the person?—a challenge because, as Lévi-Strauss spent his life showing, cultures define themselves by conventionalizing nature. They also perpetuate themselves practically by the same means. For Maring and Melanesians generally, sickness, suffering, and death have always challenged their images of sociality. Sickness unto death calls forth the individual aspect of the person in a kind of public display because no one can assume another’s pain or die for them other than by ritual transfer, which in its necessity (e.g., to perpetuate the continuity of the clan) cannot but acknowledge the reality that it seeks to transcend. Melanesian societies have used all the powers of ritual at their disposal—and formidable powers they are (Rappaport 1979)—to mask by transforming the expression of the individual aspect of personhood that is the reality of death. The modes of mourning and the rites of replacement all attempt to sustain social continuities in the face of personal loss and discontinuity. Western medicine, as advanced by state and the mission, in seeking to control the bodies of the Maring, could do so only through an exercise of power that imposed, among other things, its own epistemology of individuality. Just as the Protestant perspective thinks a one-to-one correspondence between God and person, so medicine assumes a one-to-one correspondence between medical treatment and the biological individual. The aim was to treat neither the whole person nor the community at large, simply to “eradicate the cause of infection, mend the broken part, or prevent bad outcomes”—as the VSO nurse put it. At
one and the same time, the medical professionals did not know the Maring communities in great depth and also felt certain that such knowledge was irrelevant to treating the biological individual. This articulates the Western ideology—often and situationally contradicted by Western practices—that a person’s body is separable from its sociality. In the nature of things they have an extrinsic relationship. Western notions of race and ethnicity, its theories of sociobiology and eugenics, standard medical texts on the diagnosis and treatment of disease, popular debates on whether a specific behavior (such as homosexuality) is environmentally or genetically determined, legal defenses for criminal behavior, and much more all exemplify the ideological impetus to separate biology and sociality. Simultaneously, Western views on the relationship also flow in the other direction, not least in the Christian notion of miracle and the interventions of God in the affairs of the body. The idea that if we all fold our hands and pray faithfully for the sick among us, God may answer by his healing powers. There was here a contradiction between mission and medicine, a contradiction inherent to the Western worldview, which was played out as a tension between the medical staff and the churchmen. The Anglicans desired to both separate themselves from the field of medicine and annunciate the inseparability of physical health from spiritual faith.

The relationship between biomedicine and indigenous Melanesia has been uncomfortable for anthropology because there is an enormous opposition between the acknowledged results of medical care and its political implications. On one hand, there was no doubt that health clinics, stricter sanitation measures, disease prevention programs (especially inoculations for children), and prenatal care have improved the health and life chances of Melanesians. This was anyway the Maring view. On the other hand, swallowing this biomedicine entailed their surrendering control over their bodies, living and dead, to the minions of mission and state, sometimes in ways that yielded more submission than remission. For the Maring, modernity placed everything from the way they were born and raised to the way they died and defecated under the auspices of agents and institutions over which they had little control. The use of biomedicine and belief in its authority also became a sign and weapon in the confrontation between generations. Better health care thus came at the expense of a fundamental realignment of power, the growing power of the junior generation in the context of overall disempowerment. And this is only the part of the story of power in the agentive mode. The infiltration of Western medicine also implanted an epistemology that began to transform people’s senses of body and subject. A distinction between mind and body, the principle of the body as machine (composed of genetically defined semi-automatic systems), the premise of the biological individual, the very manner in which the agents of biomedicine interacted with the Maring could not but trans-
form their categories of knowledge about subjects. The contradiction that anthropology must live with is that Western science—all science, social, medical, environmental—is both a dimension of domination and a resource of emancipation (for overturning imperial histories and perspectives, combating malaria and infant mortality, minimizing the suffering of natural disasters, etc.). In this context, the only sin worse than participating in the process of encompassment is not participating—that is denying Others the modern’s technologies of self-direction. But the story gets ahead of itself. It begins with indigenous views of causation and illness.

Community and Curing

Though the Maring have always concerned themselves with divination and curing, it was never, as in some African societies, culturally underlined by elaborate ritual or the cultivation of specialists. Matters of medicine were routinely put in the hands of all-purpose shamans. Until pacification, the growth and decline of clan clusters was yoked to the relationship between the politics of war and incidence of disease. Lowman (1980) illustrates that too great military success as well as too little could force a clan cluster into decline. Repeated victory in war would escalate the influx of affines and refugees, causing environmental degradation and a depreciation in community health; repeated defeats made it difficult for a clan cluster to attract wives and forced them to seek the protection of nucleated settlements, leaving them more vulnerable to parasitic infection (Lowman 1980:16–17). The evidence further suggests that insofar as the Maring exploit the transition zone between lowland and highland habitats, they are exposed to a greater variety of diseases than people living exclusively in one habitat or another. Most pathologies found in the Maring region are water-related, the absence of strict sanitation and water management promoting their transmission. Some of the most common diseases were respiratory infections, influenza, measles, conjunctivitis, hepatitis, various forms of worms, and malaria. Lowman (1980:210–38) observes that immunity to malaria has always been marginal and that malaria’s prevalence has increased with contact. Still, one indication that Western medicine was leading to better health was the robust population growth of the 1970s (LiPuma 1985). In the context of the increasing devotion of land to coffee growing, this was spawning problems of its own with respect to land tenure and dispute settlement. The comparative downward shift in the age of the population also increased the political power of the junior generation as indigenous politics had long correlated numbers with strength.

Especially in the early years of contact, the kiaps wore the crown of the health inspector. On their arrival, knowing the drill, the members of a clus-
ter would line up, standing straight, arms pressed to their sides, hands open, palm forward, so that the kiap might determine their “general condition.” The fear, enunciated in several of the annual reports, was that exposure to Westerners would lead to the decline of local populations, as it had in Africa, the West Indies, and the Americas (e.g., Annual Report, New Guinea 1956–57). All and everything should be done to prevent the catastrophes of other places, other times. For Maring communities, Western agents insisted that the critical measures for improving the health of local populations were the construction of latrines and the immediate internment of the dead. Part of the project of the mission and the enforcement procedures of the kiaps was to motivate the Maring to build and use latrines as opposed to the “bush.” The ever-present model was the rest house, itself located on a clan cluster’s principal dance ground, which featured an enclosure and deep-well latrine some seventy-five meters from the main dwelling. Some of the most senior clansmen officially endorsed the latrine as a matter of law while the junior generation began to use it as a matter of practice. By 1980, there were court cases in which people were fined for defecating too close to a settlement and for not building a proper latrine. For the state and the mission, and then for the junior generation, there was always more at issue than the germ theory of disease. There was also the moral governance of the body as an index of the morally sound social body. The segregation and containment of human waste was emblematic of a new sense of order, an emerging cleanliness, the concern of those “civilized” for that which passes in and out of the body. From the outset, the kiaps marked the construction and use of latrines as a mark of modernity. Where the “kanaka” would defecate willy-nilly in whatever bush was available, such seat-of-the-pants decision making oblivious to disease and ecological despoliation, the modern Maring respected proper sanitation. Hepatitis in particular was attributed to poor sanitary habits, though the building of latrines does not seem to have led to a decline in its incidence. All things considered, the most important factor in the increase in population was a reduction in infant mortality and a diet richer in protein.

The second major concern of sanitary improvement was less dramatic from a health standpoint but more so culturally. The state-created and state-enforced health code recommended the Maring revise the way they buried their dead. In the past, a raised outdoor platform was built of timber and lined with Cordyline, the sacred plant symbolizing the clan’s territoriality in which clansmen invest their life spirit. The corpse was then laid out on the platform and exposed to the elements until rotted away to bare bone. In the damp, tropic weather of the rain forest this rarely took more than six weeks. During the body’s exposure, women stood vigil because death, as a point of transition in the natural cycle, presented dangers to the living. Their attention to the platform was essential, especially the tending
of night fires to protect the dead from evil spirits and sorcerers who may approach in the form of dogs, pigs, or birds of prey. As the corpse decayed, its agnatic substances slowly dripped back into the land that conceived and replenished them. The agnatic spirit found shelter in nearby trees; the bones that remained, the essence of the mother’s contribution, would then be wrapped in leaves and later buried. Given the possibility of disease and contagion that surrounded such burial practices, and that the Maring themselves saw the attending of the dead as dangerous, a new practice developed in which the body was placed on a raised platform but now built underground. The mourners still wrapped the corpse in cloth, though now, in imitation of Western custom, it was set to rest in a roughly hewn wooden coffin. Kinsmen then placed the body on a raised underground platform by inserting it into a niche they had carved in the wall of the grave. In contrast to customary burial, there was no need to stand watch and no possibility of handling the corpse—a reality that women in particular supported wholeheartedly. By the early 1970s, both the execution and desire for the kastam arrangement seem to have expired. In the new practice, the Maring had found a way to navigate the rapids of modernity while preserving the calm of custom.

The Maring were also commanded to use the health clinic, to obey to the letter the instructions of the nurse, and to submit their bodies to new forms of equipment, typically with no explanation other than a generalized assertion of Western power. The imposition of biomedicine was inseparable from submission to the laws of an overarching authority named as the state and personified by the kiaps and medical personnel. Both thought it irrelevant that the methods, motives, and means of treatment lay beyond the walls of local knowledge. The indigenous need only grasp that their bodies were in better hands. In the early years especially, mothers were reluctant to bring their babies to be weighed and inoculated by the circulating nurse, posing a question that Western agents understood as an index of ignorance but which, from another logic, was precisely the question of those who live within the compass of kinship. What possible interest could another have in children not their own? By implicational logic, does such an interest imply that they will do to my child precisely what they would never do to their own? The issue pricked especially deep when the nurse, backed by the kiap, ordered a mother and child to report to the mission hospital for supplementary feeding. That a stranger would nurture one’s child, and with foods gleaned from the land of a foreign clan, was as alien a concept as the Maring could tolerate. The Western premise, as far from Maring consciousness as could be imagined, was that the laser of law could penetrate into the nuclear relationship of mother and child and, moreover, there existed an institutional medical
ethic and internalized occupational dispositions that, directed toward the
categorical identity patient, transcended kinship in the name of universal-
ity. In the name of the modern.

Of course, the Maring (like other Melanesians) could only begin to
grasp this from the perspective of their own universe. Though Western
agents sometimes seemed to think otherwise, the Maring could not simply
adopt a modern perspective in order to indulge in the benefits of modern-
ity. Indeed, a tenet of Western individualism is that agents are able to
self-transform their intellectual and emotional outlook independent of
their material and cultural circumstances. This ideology divides the Other,
including the “non-model” minorities of the West, into two camps: the
handful of exceptional individuals who take the initiative to transform
themselves and a vast majority who allow their material and cultural con-
ditions to impede their progress. With respect to biomedicine, Westerners
often sorted the Maring into those few who adopted a Western perspective
and were thus able to enjoy its rewards and the majority who, shackled to
local theories of illness and curing, often did not or did so only when pres-
sured. As elsewhere, the Western cultural construction of the transcultur-
— that Christ and Christianity were culture-free, that all who had an
economy could appreciate the money form, that the virtues of biomedicine
were transparent, that defining and educating the mind was the key to cul-
tural improvement— was a primary philosophy and psychology of encom-
passment.

Social and Natural Cycles

The first Westerners encountered a Maring society that rested firmly on an
opposition and complementarity between natural and social cycles. The
first centered around fertility, gardens, and women. Its logic was that of
fecundity, procreation, and growth spoken in the language of death,
deay, and rebirth. Associated especially with female ancestors, its practi-
cal philosophy was grounded in the mortality of the body, the harvest of
the gardens, fruitful marriage, and the birth of children. The natural cycle
imagined that there is a progression to all things living, a progression that
was inseparable from the organism. So it was deemed absurd that sorcer-
ers would attack the elderly, killing by mischief those who were already in
decline. By contrast, the social cycle revolved around warfare and ances-
tors, ceremonial exchanges and military alliances (Rappaport 1968). Asso-
ciated with warriors who had died in battle, with maleness and the “hot-
ness” of the head, its logic was that of violence, reconciliation, and
compensation. Its philosophy was grounded in the sociality of nomane—
the collective life force of the clan. Where the natural cycle slipped unnoticed into the house of modernity, the power of the colonial state interrupted the social cycle in the name of pacification, order, and civilization.

A practical distinction between social and natural types of illness mirrored the logic and language of these two cycles. They were the sources of the cause of illness and misfortune, the determination of cause more important in determining treatment than a patient’s symptoms or medical history. Conceptions of the cause of social illness and misfortune revolved around generative schemes for the construction of the cosmos and human activity within it. The application of these schemes imbued order and disorder, well-being and affliction, with practical meaning. As the Maring have made clear to every ethnographer, their universe begins in a foundational opposition between the realm of sociality, the locus of social and symbolic organization, and the realm of nature, perceived as wild. Maring are mid-mountain horticulturalists whose settlements are suspended in the middle altitudes between the bushlands of high and low ground. Spatial arrangements, the rituals of war and peace, as well as most ordinary activities, articulated a continuum from sociality at the center of the settlement to wildness at the periphery. Between the two extremes were gardens and sacred groves, the first associated with woman and fertility and the latter with men and spiritual power. These generative schemes could be applied to the social order as well as the cosmos. The logic embodied in the generative schemes shaped concepts of the body, health, and illness, and gave substance to the causes of distress and the modes of healing. The categories were simultaneously opposed yet complementary, mutually threatening yet interdependent (Wagner 1972). Thus the cooperation of affines in the making of exchanges and alliances, the joining of the sexes in intercourse and gardening, the interplay of the social and wild in horticulture and warfare, were essential for clan reproduction. The disorderly or anti-social commingling of these elements caused illness, misfortune, and pollution. The categories were coupled because the generative schemes always applied to action and embodied knowledge: eating with enemy clansmen or sexual congress with the wrong person at an inauspicious time or place. Disorder in the universe was not so much a conceptual breakdown, though the most reflective informants, typically those who had attended school, could conceptualize this conceptual schism, as disorder in social action, improper social uses of the body. Hence, each set of symbolic relations, each generative scheme, could be used practically as an etiology. Behaviors that abridged the customs set down by the ancestors (for example, the commandment to share pork with one’s clansmen) invited their retribution. Rivalry and bad blood among affines surfaced as sorcery (especially within the clan cluster). A disruption of proper relations between men and women resulted in pollution and ancestral wrath. The
maintenance of improper conduct with enemy clans (such as eating forbidden food) also led to pollution, weakening the body, and leaving it more vulnerable to sorcery and resistant to healing. Finally, the confusion of social and natural domains (e.g., making a garden in the bush) could provoke the attack of wild spirits that lurked outside the dominion of humans. This is worth emphasizing because there is another anthropology to the contrary. The Maring did not determine the causes of illness by acts of cosmogony; rather, the generative schemes at their disposal continually referred them back to cosmological values.

As the Maring preoccupation with center and periphery suggests, place occupied a critical position in Maring cosmology and social geography. The clan lands literally embodied the substance and history of clansmen. The cycle of social reproduction interlinked food, land, procreation, and death with the formation of agnatic identity (LiPuma 1985). Clan territories were divided into discrete named parcels of land, each of which had its own character based on the history of residence and production in that locale. The special affinity between clansmen and place meant that when people traveled to foreign and thus alien places, they were liable to be taken ill. Since contact, men have gone to coastal plantations where they occasionally died or had bouts of serious illness. Maring linked these deaths and sicknesses to the hostility of the environment (including the presence of sorcery for which they possessed no countermagic). Medical rationality may observe that coastal environments were truly more hostile and unforgiving, especially to Highlands peoples. Just as Maring history elided people, places, and actions, so their concepts of illness also bundled these concepts. But this was only part of what Maring meant, for disease and misfortune were diagnostic of the disharmony between clansmen and land, not the cause. So when illness struck hard, clansmen typically shifted their settlement compound to a more auspicious site. The old houses were razed and new ones built on another territory, usually in the same vicinity. Residence shifts seemed especially common when an influenza epidemic broke out.

The disorderly confluence of elements was not the only basis of illnesses and afflictions. Maring recognized that in addition to social relations there were various natural diseases and ailments. The natural cycle was a perceived continuity between procreation, growth and development, and old age, followed by death, decomposition, and decay, leading to fertility and the rebirth of one’s descendants. The natural register represented the orderly, inevitable, and unceasing progression of elements. People’s residential arrangements, adherence to food and sexual taboos, and participation in ritual were conducted in terms of this cycle. Like other Melanesian peoples (see Herdt 1989), the Maring entertained a nurturing/atrophy theory of the body and its vital fluids. The body and fluids of
children were built up through the nurturing acts of their kin and their own self-restraint (e.g., observance of taboos and, in the case of men, avoidance of sex) until they gained the full powers of adulthood after which the obligations of sociality (e.g., procreation, childbearing) diminished and exhausted their vital fluids and organs, leading to death, decay, and renewal. The young and old, far from the fullness of power, were the most susceptible to illness and the maladies of the natural cycle, whereas only sorcerers and evil spirits could fell adults at the height of their physical prowess. We can summarize Maring accounts of illness, curing, and cause as follows:

**NATURAL CYCLE**

<table>
<thead>
<tr>
<th>Minor ailments</th>
<th>Life-threatening illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and elders the most likely to be taken ill</td>
<td>Adults, especially mature and important men most likely to be stricken</td>
</tr>
<tr>
<td>Indicates progression of the natural cycle</td>
<td>Indicates social disharmony and disruption of the social cycle</td>
</tr>
<tr>
<td>Causation was natural</td>
<td>Caused by sorcerers and ancestors</td>
</tr>
<tr>
<td>Cured with local, everyday remedies</td>
<td>Cured through the diagnosis and magical healing of the shaman coupled with the sacrifice of pigs to the ancestors’ spirits</td>
</tr>
</tbody>
</table>

**Concepts of Illness and Health**

Nowadays we have fewer shamans and more sorcerers.

_TIPiKA, 1980_

Social illness had the following appearance. A person’s or a clan’s behavior breached norms regarding the proper relationship between categories of social beings or, what amounted to the same thing, between persons and land: ceremonial food was stolen from the garden of another, at the moment of consumption ancestors and kin were denied by an act of selfishness (i.e., individualism), food was eaten or sex consummated with a taboo person (the Maring culturally specialize in taboos, having many and intricate varieties), or sorcery was employed on one’s own clan members. Depending on the nature of the offense, this would incite the attack of ancestors, sorcerers, or wild spirits. These attacks caused physical distur-
bances of some kind. Food may blockade a critical body canal, such as the windpipe, or a poisoned object may be implanted in a vital organ (especially the liver). The result was a physical/spiritual transformation of the person, as characterized by pain and loss of mind, implying a descent toward death. The disregard for the morality of relations at once material and social invited misfortune to body and soul, substance and spirit. On this reading of the world, the process of curing never begins by amputating body from mind, the person from society, in order to isolate and analyze the illness. It is no surprise then that this way of thinking-the-world read symptoms and named causes rather than diseases. The aim was to deploy a batch of schemes immanent in practice that, by opening the windpipe or removing the splinter, reversed by a kind of symmetry the social, spiritual, and bodily damage that the attack had done. The goal was not to isolate and analyze, but restore the wholeness that immorality ripped asunder. The tracks of this implicational logic run in both directions, the goal of the shaman to reverse the descent into death by triggering a flow in the opposite direction. And so a man who has consumed pork alone in the bush, angering the ancestors who oversee sociality, leading to the penetration of his liver by bamboo spikes that renders him delirious, invokes the shaman who by removing the offending splinters causes the victim to offer the compensation of pork to ancestors and affines, thereby restoring his sanity, sociality, and body. A collectively approved public denial, the rites of curing were designed to negate and neutralize the dangerous forces released by the transgression of limits. Their goal was to put the genie back in the bottle.

In this respect, the shaman was a mortal and moral contradiction. He was by character and circumstance an expression of the individuated aspect of the person, chosen, precisely because of this, to function as the authorized delegate of the community in the service of the restoration of sociality. Curing and sorcery, both shamanistic powers, were opposites joined at a deeper level: sorcery, a species of individualistic expression that enervated the social world in the interests of the separated self; curing, a species of individualistic expression that revealed, reversed, and restored the social world in the interests of the community. So the shaman was himself a sacrilege. A man who transgressed the limits of agents and agency in the process of resurrecting the limits transgressed. Shamans were, in Maring words, men who “stand apart” and “live by themselves” and are obsessed by secretiveness. Not surprisingly, given their ambiguous position in social space, they appear as both saviors and scapegoats—as heroes of curing and perpetrators of sorcery. The logic of practice and power could not but fuse the shaman and sorcerer, the practice of medicine with the art of harming. But far from disturbed by the liminality of the shaman, the essence of ethnomedicine was to harness position for purpose.
The shaman as a personification of the individual aspect of personhood also had other expressions. Most people claimed that they did not know the methods of the shaman, or even if there were accepted techniques. For their part, the methods of the shamans I interviewed were amazingly individualistic and eclectic, a symphony of elements imported from other cultures, improvisations on existing themes and means, and the legacy of their own secretive and individualistic teachers. Aware that they could both harm and heal, that their intentions were impossible to divine, and that the distance between shaman and sorcerer was a matter of circumstance, people regarded such men with a mixture of fear, awe, and curiosity. The power to remove a curse or bamboo knife from the afflicted—with techniques as various as the shamans themselves—was also the power to levy or implant them. In fact, it may be said that the power of the shaman/sorcerer derived precisely from his acts of individuality meant to express the individuated aspect of the person. So the paradox of modernity that the elder statesman and shaman Tipika alluded to above. With the accelerating ascendance of biomedicine, there appeared to be no new shamans-in-training, no young healers learning and waiting offstage to assume the wisdom of their fathers (see Barker 1989), even as the incidence of sorcery and the presence of sorcerers were on the rise.

In contrast to its social counterpart, the Maring associated natural illness with the developmental and aging process. This covered a broad range of pains and ailments from teething and tooth decay to the bowel and joint problems suffered by elders. For the most part, natural illnesses were associated with stages in the life cycle—certain diseases common to infants, or menstrual cramps for women. As long as an illness was consistent with the natural cycle, and within the more specific life cycle of the person, it was not thought to be the patient’s fault or the result of sorcerers or angry ancestors (cf. Ngubane 1977). The line between social and natural illness was not, of course, always transparent; especially when an illness deepened, shamans were called upon to divine its status. In more than a few instances, shamans reclassified an illness originally thought to be of natural causes as having a social etiology. The assumption was that natural illnesses were mild and episodic, that those in the prime of life did not, could not, succumb to them. The classification system had less to do with the cause of an illness than with its consequences. Time and again, for example, agents would classify the flaring of chronic low-grade malaria as natural, as a small discomfort that ambled in and out of a person’s life, whereas nothing was more obviously socially induced than a bout of life-threatening cerebral malaria. As illnesses, they had nothing in common of social import. Sorcery trials, whose touchstone was intentionally motivated disease and misfortune, did not center on natural illness, but on the
socially defined asociality of sorcerer and victim. In this light, traditional curing had two main objectives: to eliminate the magical cause of physical death and to reconcile the troubles that engendered the attack in the first place, the assumption being that unless the victim’s family placated the aggrieved ancestors, sorcerer, or wild spirit, then the assaults would continue until death arrived.

In general, a person who contracted an illness underwent a change in internal state. This could be either a natural part of the inevitable cycle, or else a socially induced transformation brought about by the intentional acts and intervention of spirits and sorcerers. Within this frame, health depended on two things: first, the harmony or balance (kopla) that a person maintained within the social and cosmological order; second, an individual’s personal strength and recuperative powers. People’s strength and regenerative powers were thought to diminish as they became older, as did their resistance to disease (see Lewis 1976:96–98). By 1980, people came to believe that Western medicines were superior in the treatment of natural illnesses and so they were seldom afraid to go to the health clinic to capitalize on the availability of Western drugs. By contrast, especially for the older generation, biomedicine was thought to have little effect on the outcome of socially induced harm, although it might be effective in relieving symptoms and assisting the body’s normal regenerative powers. How the kinsmen of the stricken chose to treat an illness was also the site of confrontation between generations and medicines. These two processes were articulated in the mission hospital when a victim of sorcery suffering an illness received the dual care of a shaman who extracted the slivers of bamboo lodged in the liver while the nursing staff administered Western penicillin to check the infection. There was no sight more representative of the two medicines, the colliding epistemologies, than the Western nurse, her stethoscope suspended from her neck, standing on one side of the patient while an elder shaman, a small string bag dangling from his neck, stood on the other, all encircled by family members who took very different positions on the merits of treatment. The nursing staff and the man’s educated son believed firmly in the virtues of biomedicine, the shaman in his powers to thwart the progress of the ailment and discover the troubled sociality at its source, while the majority held to a dual epistemology that sought to combine the medicines for whatever it might be worth.

Ethnographic Interlude

One day as I sat with the shaman Tipika, a man of renown who had taught me an extraordinary amount about his magic, and three young men in their early twenties who had attended the mission school, we talked,
among other things, about my most recent match with malaria: an attack that lasted a few days until one of the members of the quinine family had put it back to sleep. One of the young men, repeating our earlier conversation on the same subject, observed, glancing at me to augment his authority, that when mosquitoes bite us they give us an invisible virus that causes malaria, all kinds of malaria—great fevers and small. This flew in the face of the local premise that illnesses of differing severity must have different causes, and it further implied that malaria belonged wholly to the natural cycle, a phenomenon within the province of biomedicine. The remark was contentious because it eroded the ground of the elders and the shamans. When I earlier talked with the young men, my sole intention had been to explain how Western medicine understood malaria, though clearly, in the Maring’s ongoing struggle for understanding and between generations, even innocent comments, that is, seemingly objective because factual from my perspective, were potentially incendiary. Not to be so easily consigned to the fires of modernity, Tipika turned to me and asked, if I knew all about what he called the “fever,” could I please explain why some mosquitoes decided to only pester their victims whereas others wanted to kill them. And did I not think it a bit strange that mosquitoes, small brainless creatures that they were, would be making such momentous decisions about the health of humans? Wasn’t it more likely that the mosquito was really a transfigured sorcerer? Or that a sorcerer poisoned the person? It was clear that his magic was the vessel into which he poured himself. He was not about to give it up, to be reduced to simply playing an ancient part now rendered meaningless by the modern. I could, of course, have explained that being bitten and by an anopheles mosquito was largely a matter of probability and chance. But I doubt the notion that nature plays craps with human life would have offered more than the coldest comfort, intellectually or emotionally.

Tipika continued, the others listened. He said that men like him were especially dangerous nowadays because they have freedom and anger: the freedom to “gather” magic from anywhere and anger born of watching their world crumble. Tipika said that he did not care about the mission and did not want to be like the priest. He did not care about the health center and did not want to be a doctor. I realized that most of all he did not want the status and role assigned to him by modernity. He desired not to succeed at this status and role of shaman but to flee from it. To return to a promise in which the modern did not grow like a rind between him and his practical magic. A world in which the young men he called “sons” did not see him through the prism of the modern, which transformed his fight magic, his power to cure, into an emblem of what was being left behind, what his sons needed to forget to get on with their lives in a Westernizing world. What he was saying, and profoundly, is that to have a world
imposed upon him in which he is seen as enacting his customs is to become estranged from his culture. As he said to me on an earlier occasion, “I might as well teach you my magic, no one else is interested,” his hand sweeping out dismissively at a knot of young men gambling dice. What the shaman was saying subtly but audibly was that the very act and fact of recognizing him as an ethnomedical specialist, and the transmission of his knowledge to me, his satisfaction of my desire to know his culture, was part and parcel of the encompassing process. On another occasion in the same vein, Tipika said that the new road was neither inherently good, nor bad: simply what was. But that did not dispel a note of personal anger.

Medical Care and the Anglican Mission

The first plans of the Koinambe mission station (ca. 1966) drawn up by Father Etterley included a hospital. By the early 1970s, the mission had built the hospital with its own funds, complete with an outpatient clinic, sick ward, plus examination, supply, and operating rooms. The hospital was staffed with a head nurse from the Volunteer Service Organization (VSO) assisted by medical orderlies and local nurses from long-established Anglican areas. The mission also inaugurated a tradition of monthly village patrols by the VSO nurse to improve pre- and postnatal care, dispense medicine, and send those in need of acute care either to the mission hospital or to the regional medical center in Mt. Hagen. In addition, medical outposts staffed by a local trainee were established in almost every community. Inscribed in the division of labor between medicine and mission was a separation of church and science, a recognition that repairing the body was of a different order than redeeming the soul. Both required specialists who, occupying different positions in intellectual space and indeed embracing different visions of health and well-being, could not but exist in an uneasy tension. After a brief period of reluctance, the Maring developed a taste for Western medicine, pharmacopoeia, and techniques. It was a new and complementary source of power that the younger generation especially could tap in pursuit of its interests.

For the Maring, the hospital was to the church as the deed was to the word. Their view was that the truth was inalienable from action. No amount of preaching about the powers of the Almighty was meaningful without concrete observable acts of power. And, as noted earlier, the Maring motto was never “In language we trust.” On this perspective, the health center was more powerful than church services though less than the trade store. The Anglican Church, like most mainstream churches in New Guinea, believed that providing medical services was part of its mission to serve the body, which keeps the soul. This dovetailed with a theme
repeated time and again at evangelical conferences: that traditional religions were dominated by fear whereas Christianity was rooted in love. The local view that ancestors will cause death and illness lent support to the idea of a religion of fear and trembling. Against this world radiant with harm, the Church believed that to open people’s hearts and minds to the Good News of Christ’s love, it must show that it could deliver the community from illness, that the Western God was not a master of punishment to be feared, but one’s ally in the quest for health and well-being.

During the late 1960s and early 1970s, a string of aid posts was established in most of the local territories. The aid posts were established in terms of population densities rather than political boundaries. In some cases, two clan clusters who had been opponents in the wars of the 1950s and who currently opposed one another politically were assigned one post, and the aid post was sited on the land of one of the clan clusters. This led to situations in which a vanquished clan cluster had to visit an aid post located on the land of their traditional enemy (in some cases the APO was also from an enemy clan). The mission was only too aware of these political rifts but felt that the key to promoting a Christian spirit and to unifying the various groups lay in overcoming old animosities. In the same image, the aid post like the main road and the mission station itself was to be a modern public space that belonged to everyone because it belonged to no one. As in the case of the modern system of justice, there was supposed to be a transcendence of kinship—a notion of duty and commitment to the sick that inhere in the position independent of the person. From the vantage point of the Westerners, the key to finding a good APO was to find someone who could begin to appreciate Western ideas of science and who would be immune to the “pull” of kinship and/or the demands of exchange relations. Moreover, in order to relieve the burden placed on the mission hospital and to distribute health care more widely, the mission in concert with the state sought to empower local aid post personnel by placing more resources, authority, and monies at their disposal. This also fit the overall program of transferring oversight of rural medicine from Western to Melanesian hands. The logic of the progress of medicine could not but help to empower the junior generation as they alone were capable of meeting the requirements, objectively by virtue of their education and language skills and subjectively because Westerners felt more comfortable dealing with them.

There was a deep contradiction in the Anglican view of medicine, a contradiction also present in its Western incarnation, which was part of the stowaway baggage imported to Melanesia. On the one hand, they wanted the Maring to subscribe to scientific theories of disease and treatment, thus demystifying the issue of health. This was thought necessary because indigenous views of illness and curing were inseparable from
indigenous religion and cosmology. To destabilize and dislodge local notions of sorcery especially, people had to adopt, however rudimentarily, Western ideas of biomedicine. As one missionary explained, people had to realize that illness had to do more with germs and proper sanitation than with “incantations mumbled over the victim’s fingernails.” Here the Protestant ethic and the spirit of science were fellow travelers. Yet, simultaneously, the mission taught that health and sickness depended on the will of God—Who could be approached only with one’s hands folded in prayer. The efficacy of pills and injections was in His hands. This view could only undermine the very biomedical view that Church personnel were instrumental in promoting. In the practice of everyday life at the mission station, this spawned an inherent conflict between the views of the priest and those of the VSO nurse: indeed, on one occasion when the priest called for prayer she called for an emergency plane to evacuate a desperate patient riddled with malaria. This was by no means an isolated event; simmering disdain was always just beneath the surface of the cordiality demanded in the frontier setting. The VSO volunteers and the physicians that occasionally visited in no way imagined that it was their task to assist the mission in converting the local populace.

Maring thought of Western health care as a new inventory of practices rather than as an alternative system. They overlooked its systematic aspect, conceptualizing it in the light of ethnomedicine, which, indeed, was not a natural or bounded system (see Comaroff and Comaroff 1991:367). By contrast, Western health workers and clergy viewed “traditional” and “modern” systems as diametrically opposed: the hospital fighting a battle for men’s bodies just as the Church fought to redeem their souls. Like the Maring, Western health workers perceived all of medicine through the prism of their own system. Thus they imbued ethnomedicine with a systematicity and closure it could never possess. They believed the Maring had to choose between competing and alternative medical systems. In the eyes of mission-educated Maring, more than the Anglican mission itself, this choice was a referendum on modernity. And so an express goal of the junior generation, delivered formally as speeches at the weekly market and informally through their influence on their kin, was to urge people to use the aid post and mission hospital, not only when they were ill but for preventive care as well.

The Evolution of Pluralism

Maring initially perceived Western medicine as part of the enormous, yet incomprehensible powers of the West. They understood that biomedicine was strong but also fraught with danger. Thus in the early years of contact,
fear led people to avoid the aid posts and the health center. During this period, roughly from the late 1950s to 1970, they did not perceive Western medicine as medicine, but as part of the conquering process at the hands of the Australians. Hospitals, examinations, and policies to maintain health were not in the inventory of Maring practices. The elder generation, then in power, could do nothing about the “visits” of medical personnel armed with the kiap, but they could rebuff the attempts by the Australian administration and the Church to get people to use the health facilities. But more than any deliberate policy, people avoided the clinic and health-care givers because their methods and sociality lay beyond the compass of indigenous epistemology.

This initial phase of contact gave way to a second phase in the early 1970s. Its principal artery was the steady incorporation of biomedicine into the distinction between social and natural illnesses. Biomedicine was thus seen to specialize in promoting the body’s natural regenerative powers. People felt that it was a greatly enhanced version of their own natural treatments, such as rubbing with nettles or the ingestion of plants. While the elders continued to steer clear of Western medicine, the senior generation refined their epistemology into a hierarchy of resort (Romanucci-Ross 1977). The organizing principle was an implicational logic that, by deriving its first principles from sociality, bore no relationship to a Western medical logic. If the aid post or health clinic could treat an illness—and the Maring were openly receptive to inoculations and pill-taking, as these paralleled long-standing ethnomedical prescriptions—then that illness belonged to the natural cycle. It concerned only that person and was therefore minor—or, better, was minor because it did not signal a disruption of community. By contrast, serious intractable illnesses, resistant to biomedicine, were clearly the harming of sorcery and spelled a dissembling of community. Clansmen soon began to see that they could use Western and ethnomedicine in complementary fashion.

While the Maring conceptually harmonized the two species of medicine, they were still divided at the level of practice: for the local populace played no part whatsoever in administering Western medicine. It was still at this time presented as a foreign knowledge beyond their constricted capacity to manage or understand. The difference between simply receiving medical treatment and participating in its practice was inscribed in the social structure of medicine. The management of biomedicine had three tiers. At the top was a nurse from Volunteer Service Organization of England. During the 1970s, there was a succession of VSO nurses who organized and directed the health center at Koinambe. Assisting the VSO nurse were junior nurses, almost always from coastal areas where the Anglican mission had been operating for nearly a century. At the bottom of the hierarchy were local orderlies who did cleaning and carried heavy loads. The
social hierarchy expressed the view that Westerners were more capable of administering biomedicine than coastal Papua New Guineans who in turn were more capable than Maring. Westerners, coastal New Guineans, and Maring all shared this viewpoint, which was objectified in levels of perceived competence (defined as length of medical training, knowledge of English, and ability to understand Western forms of reasoning).

An important though underestimated instrument of change was the medical patrol conducted by the VSO nurse. The road show moved the medical hierarchy from community to community, displaying the social order of medical care. Given their perspective that knowledge/power were inseparable from sociality/habitat, the Maring took it as axiomatic that Westerners knew more about the science of medicine than Melanesians knew or could know, reasoning, as one senior clansman phrased it, “that sorcery and the forest have secrets that belonged to us while your medicine has secrets that belonged you.” More, the patrols were indoctrinations in Western medical values. For example, the questions addressed and the responses required of a mother when the nurse examined her children presumed and entailed that she assimilate Western medical concepts. The nurse’s grading of the health of children (like her questions as to the degree of health/sickness) assumed health and illness existed on a continuum. This contrasted with the indigenous version that while there were various degrees of health and illness (i.e., those who were ill may improve or become worse; those who were healthy vary in strength), health and illness were opposing states: people were either sick or healthy. Similarly, the idea that every ailment had a natural cause and a medical therapy—first and final chapters in a tale of diagnosis, treatment, and recovery—was foreign to local values, which never isolated the biological individual.

In the 1980s, medical care began to enter a new phase that promised to accelerate the Maring adoption of biomedicine. The linchpin of change was the growing local participation in the health-care system. Local aid post orderlies, especially in the Jimi Valley, began to replace their coastal counterparts. On the same note, a Papua New Guinean was promoted to the position of head nurse at the Koinambe hospital, a point that greatly impressed many Maring. At this historical juncture, the junior generation paid little attention to ethnomedicine other than simple practical therapies, such as chewing ginger for a toothache or rubbing the skin with nettles to stimulate blood flow. Many of them assumed what the mission preached, that God had trumped the sorcerers and that biomedical regimes could best treat all illnesses, no matter their genesis. There emerged a close correlation between generation and how agents perceived illness and utilized therapies. The elder generation characteristically responded to serious illness by calling for a shaman and then, after he identified the social breach and the enraged ancestor, his kinsmen...
sacrificed a pig to the spirits to petition for recovery. Almost invariably, the elders refused to go to the mission hospital, spurning requests from their children and especially their grandchildren. The senior (middle) generation was most likely to take the most pluralistic approach to treatment, usually receiving both ethno- and biomedical care, though rarely did they sacrifice pigs to the ancestor spirits. Finally, the junior generation often went directly to biomedical care and Christian prayer, sometimes showing marked disdain for traditional remedies. Indeed, there emerged a kind of powerful cultural polarity in which the junior generation would openly criticize customary formulas whereas senior and elder generations would abstain from publicly criticizing Western medicine.

*Symptoms of Change: A Case History*

The following case history gives a sense of the reality of social change as experience. It also illustrates key elements of the Maring approach to sickness and health in the context of modernity—the tension, the ambiguity, and the clash between generations. The time was January 1980 and the setting is the Kauwatyi clan cluster, Punt being a leading big-man of the second most powerful clan. As noted, the Kauwatyi maintained a particularly ambiguous relationship with the Anglican mission. Nonetheless, due to the fact that they were land-poor, the Kauwatyi were leading exponents of modernity and had invested their own money and labor in the construction of larger and more sophisticated facilities for the local APO. In the continuing generational struggle, the senior Kauwatyi leaders believed that the junior generation was using the mission to challenge their authority and control. So in their desire to keep the mission at a distance, they expelled the Anglican evangelist and did not actively participate in festivals and other ceremonies organized by the Church. The result was a continuing tension between embracing modernity—medicine and education especially—and maintaining a Kauwatyi identity.

*The Medical History*

Punt, an important man in his mid-fifties, took seriously ill. He said that something was blocking his body’s canals, causing fever, chills, slack skin, and a loss of spirit. He withdrew from all social life into the recesses of his hut, feeling that the weakening of his body rendered his *min* (life force) susceptible to further attack from sorcerers and evil spirits. Punt was in a state of physical and spiritual decline. His body was racked with fever, and he worried that he was losing his hotness and dryness. He avoided washing as
the cold, damp water would only accelerate the process. He sat by the fire inhaling smoke to help restore his heat/dryness and rubbed his arms and back with stinging nettles to produce heat and excite the flow of blood.

But preliminary treatment was ineffective, and Punt became progressively sicker. He waxed hot and cold and appeared to be dying. His younger brother suggested the cause of the illness—ancestral anger over a long-past and nearly forgotten failure to sacrifice pigs in their honor. They had withdrawn their protection leaving Punt vulnerable to attack by sorcery. The logic was simple, unassailable, and implicational: if the illness was not natural than it must be social; if a strong and apparently healthy senior clansman like Punt could be so thoroughly decimated then his ancestors must have withdrawn their protection (and conversely, his long history of good health must have been due to their intercession on his behalf); if their protection was removed Punt would be vulnerable to sorcery; and if he was the subject of sorcery it must be because he had failed to repay a debt. On this logic, Punt had twice failed the test of exchange, once with his ancestors and then again with an exchange partner. The brother then planned a sacrifice to propitiate the disenchanted ancestors and to ask them, through the medium of the shaman, to identify who he had slighted in exchange. Some said the brother was anxious to make amends because he was party to the offensive actions and was now gripped with fear that he would be next. In any case, the subclan prepared to sacrifice a pig to the ancestors.

Punt’s son, who lived at Koinambe and worked at the mission hospital, came back to the settlement to see his ailing father. He judged that earlier treatments, the rubbing with nettles and visits to the APO, had been ineffective. With scant ceremony or consultation he removed Punt to the Koinambe hospital. At the hospital, the nurse diagnosed the illness as cerebral malaria and directed a junior nurse to begin treatment. But Punt’s son objected, saying that because his father was dying he wanted the white VSO nurse to administer the tablets herself. Later in the day, the nurse informed the Anglican priest that Punt was likely to die.

Punt’s brother raved that he was furious with the ancestors. He noted that many clansmen were no longer making regular ritual offerings, and that, moreover, his previous sacrifices had produced little in the way of ancestral help. To darken matters, Christ was no help because he was unconcerned with sorcery. So now the ancestors were taking revenge. Stripped of protection, the man was easy prey for sorcerers who coveted his pigs—pigs that should have been sacrificed and given to ancestors and affines. The day following Punt’s admission to the health center, a Kauwatyi shaman arrived with a small entourage. Shortly after arriving, he pronounced that a sliver of sorcerized bamboo had penetrated Punt’s liver. While Punt was writhing on a small cot, delirious, making unintelli-
gible sounds, the shaman took a bamboo tube filled with bespelled leaves, among other items, and worked a cure. The spell was not said in Maring but in bastardized Kalam, the language of the neighboring people.2

At the same time that Punt’s brother was fetching a shaman, Punt’s son, a loyal churchgoer, was telling the Anglican priest about his father’s plight. That same day the priest announced from the pulpit that there was a dying man at the hospital who needed their prayers. He told the congregation that only the intercession of God could save him. For three days Punt hung on. On the fourth, his fever started to subside and his recuperation began. The Anglican priest proclaimed a miracle from the pulpit and over the shortwave to other missions. He rejoiced that God had seen fit to show the Maring his power. The shaman told me that his magic dissolved the bamboo and stopped the sorcery. The VSO nurse, Catherine Sutton, told me that the actions of Punt’s son coupled with the administration of primaquine and the patient’s generally sound health saved the day. She also confided in me that she did not know who was more absurd, the shaman or the priest, and then after a moment’s reflection, she selected Father Bailey as the more absurd “because he should know better.” But given the joy of the situation, there seemed more than enough credit to go around and no dearth of willing takers.

Responses to Illness

Here, as in numerous other instances from this period, Maring patients made use of both forms of medicine, separately and in tandem. While Punt’s son favored Western therapy, he made no effort to halt the ethnomedical cure and indeed was present when the shaman performed his magical surgery. Somewhat uncertainly, he accepted the premise that when persons are gravely ill, their kin must tap all sources of power until they are cured. Throughout, treatment was plural and cumulative. A failure of the preliminary therapy of stinging nettles and fasting led to a visit to the aid post, which, proving ineffective, led to hospitalization and employment of a shaman. This was the progression of medical treatment, clearly a change from only a decade earlier when many fewer people used the hospital and consulted the shaman first. The example underscores the complementarity between Western and indigenous medicine, between focusing on its physiological versus its social causes. By 1980, most Maring believed that the treatments offered at the aid posts and health centers assisted the body’s natural processes and were, in this respect, superior to ethnomedical remedies. There was an analogical transfer of schemes from ethnomedicine to biomedicine. If an indigenous medicine relieved pain by causing blood to rush, and a Western medicine better relieved the same
pain, then the Western medicine must have achieved success by circulating blood more effectively than the indigenous one. The mainstream view was that Western medicine was a therapeutic magic that specialized in aiding the body’s basic recuperative powers. It could not, however, counteract the ravages of sorcery or spiritual siege. The sorcerized bamboo sliver would cause death if not removed with techniques beyond the purview of Western medicine. Moved by an implicational logic, this fostered the notion that if biomedicine could not cure an illness then the illness must be the result of sorcery or malevolent spirits. In such cases the wisest course of action was to combine Western and indigenous treatments. So the malarial medicine was seen to strengthen the patient, a positive mobilization of power vested in the competence of Western medicine. The divination and magic was aimed at removing a continuous agent of death—the sliver of bamboo—thus eliminating an inevitable because unremedied cause of death (Glick 1967). And there was in all of this an air of practical experimentation. In one case, a young man who had attended school, worked for the mission, and aligned himself on the side of biomedicine called in a shaman when Western remedies failed to calm his illness. An opposite example was an elder clansman who sought Western medicine when, after receiving the help of a shaman, his condition continued to deteriorate.

The attitudes of Punt, his brother, and the shaman capture the indigenous conception that illnesses are specific to persons. There was not an entity, a given disease type, that attacked an individual, exhibiting its effects based on the physical state of the victim, the strength of the disease, and other factors. Rather, illness was a specific transformation of the person from a potentially identifiable cause. Within this framework, diagnosing the cause of the illness was less critical than the administration of treatment. In some cases, the initial cause of the illness (e.g., failure to make ritual sacrifices) was only divined after the patient has been treated (cf. Johannes 1980:51). Similarly, the means of sorcery, its reasons, or how the bamboo sliver entered the liver were not relevant to treatment. The case also illustrates the contradiction inherent in the Christian view, which both wanted to extol the virtues and value of medicine and the health center and, at the same time, wanted to oppose the separation of the science of healing from the Word of God. Certainly the priest’s claim that only God’s hand could cure Punt seeks to reunite them.

Medical History and Cultural Prognosis

It should not be ignored that the social organization of illness always fulfilled a political function by defining the limits of health, boundaries that differentiate healthy from sick people, the social limitations imposed
on those who are ill, and the duties, responsibilities, and privileges of health. But medical pluralism among the Maring touches the social polity in another decisive way. The use of Western medicine and the uses made of it became enmeshed in social and political strategies and instigated generative changes in people’s epistemology, desires, and dispositions—changes that stretched well beyond the limits of medicine. After a quarter century of encompassment, the local political structure, led by the senior generation, allowed a pluralism that combined ethno- and biomedicine, even as the evolution of medical care was gravitating rapidly toward the latter. A critical register of change was people’s categorization of illness, these acts of classification simultaneously defining the appropriate treatment and reproducing a practice of medicine. In the hidden hand of history, people were progressively, gradually, and practically classifying more instances of illness as belonging to the natural cycle. Thus classified, they were amenable to Western therapy and outside the scope of ritual and magic; there was no need to call upon shamans to identify the social sources of the sickness, nor was there a reason to presume that anything was amiss socially. Thus agents saw little point or merit in, as one young man put it, “wasting pigs on the ancestors.” Reciprocally, the successful treatment of an illness by Western medicine implied that the illness was natural rather than social. This was a point that the medical and mission personnel made often and in various ways, perhaps most dramatically when they preached, as they did repeatedly, that people died from infections not because they had been attacked by a wayward spirit or sorcerer, but because their kinmen had not brought them to the clinic soon enough. To summarize the argument: the model of medicine being produced from the encounter between the Maring and mission was not the result of a logical combination of indigenous and imported brands because it was mediated by generations very differently constituted and positioned with respect to the social system.

The notion that the natural cycle was on the ascendency fit local concepts of modernity. The junior generation in particular believed that pacification and the turn toward law had all but extinguished the social cycle of war and peace. Accordingly, the “red ancestors” who had once presided over the cycle were increasingly irrelevant to the reproduction of the clan and the well-being of its members. In that same dimming light, relationships made with affines because they could serve as military allies and ports of refuge were diminishing in importance. Pacification, coupled with the new opportunities provided by modernity and the ascendancy of women to determine their own future, allowed marriages to be made far and wide. This was part of a more general process in which things social were re-presented as natural even as a Western notion of the social—predicated in large part on the disenchantment of nature—began to take hold.
In this respect, biomedicine was part of the introduction of a notion of nature that imagined biology and environment, body and place, as extrinsic to the social.

The influence of the Western medical system was founded at least in part on the reality that it was a system, in contrast to ethnomedicine, that existed entirely in a practical state. From the standpoint of local healers, biomedicine was part of the overall weakening of Maring society, which they had come to accept as inevitable. Their authority had been founded on a monopoly on competence: their ability to remedy serious illness by divining its genesis, deploying the technologies of magical healing, and repairing the rents in the social fabric caused by the wanton transgression of limits. With the advance of the modern, the shamans lost their monopoly twice: once to Western medicine and again to a younger generation who had special competence in opening the corridors to biomedicine. Nothing illustrated this more than the dearth of shamans among the younger generation and their disposition that shamanism was part of the deadweight of the past. Beyond that, many members of the junior generation simply disregarded traditional notions of the transgression of limits, thereby redefining these limits and their implications for the construction of sociality. They especially ignored the elaborate catalog of food taboos, and the generative schemes whose enactment continually and practically divided the social field in respect to circumstances. Those who were more aggressive in their Christian faith even prided themselves on their willingness to forsake the food prohibitions specific to their clan and the taboos on eating the food from, or dining with, an enemy clan cluster. The circulation of food at the Koinambe station, which housed members of formerly warring clan clusters (e.g., the Cenda and Kauwatyi, traditional enemies, represented more than half the population), exemplified a new willingness to discard old limits in the interests of new realities. Spurred on by the mission men, they rejected the thought that eating alien foods could have medical consequences. The medical field was thus instrumental in a three-dimensional shift in power: from shamans to physicians and other health-care givers; from a customary set of social limits to a modern one; and from the senior generation to their juniors.

A characteristic of ethnomedicine generally and Melanesia specifically is that there is no separation between technical medical and ritual action. In this union, all treatment was on a case-by-case basis because Maring believed that the conditions of community, the behavioral history of those involved, and the action itself were all relevant. Healing passes from the specific illness and its causes to a specific cure, all of the while invoking symbolic means toward biomedical ends; the logic flows upstream implicationally from the symptoms and disease of a person to its cause—young men, for example, who are victims of malaria must have
been the object of sorcery whereas old men who suffer the same disease may do so naturally. Moreover, there can be no field of medicine because there is no distinction between the person and position, between, for example, the shaman and the kinsman. Finally, for the same reasons, the practices of the shaman did not have a social space that corresponded to them. By contrast, the Koinambe mission station was an education in the definition and orchestration of fields. The religious sphere was commanded by the priest, housed in the church, and centered on the action of praying. The medical sphere was commanded by the nurse, located in the hospital, and centered on the actions of prescribing medicine, giving inoculations, and performing surgery. If the Church’s domain was the soul and spirit of the person, the medical system concentrated on the body to the extent that often little or no social interaction passed between nurse and patient. The rotation of nurses also underlined that the persons were interchangeable because what mattered was that the position be occupied by a capable (i.e., medically authorized) individual. By 1980, the Maring had only begun to appreciate the construction and differences between fields, though the mission station served as a permanent model and its agent used the distinction between fields as a reason that was also a cause of action. Whenever anyone was seriously sick, this justified summoning the nurse immediately, almost ceremoniously. On several notable occasions, the Maring carried a sick man to the house of the priest and requested that he send the patient to the Mt. Hagen hospital, but the priest deferred that judgment on the grounds that it was the nurse’s decision, she being the medical expert.

The infiltration of Western medicine also inflected the subjectivity of the Maring and the conditions of its construction. People came to believe in its power to help them and grew in their desire for its pharmacopoeia and technologies. Particularly those of the junior generation but also some seniors and a large cross section of women became disposed to use it as the medicine of first resort. No longer dependent on entangling kinship relations, and all the hierarchies and enduring obligations this entailed, the aid post and the mission clinic offered the opportunity for greater autonomy. This autonomy of the body became a metaphor for the expression of the individuated aspect of the person, part of the more general process in which the modern made individuality a progressively more acceptable form of being-in-the-world. Self-control over one’s body meant that people were free to select their marriage partners, self-decide what food taboos they were going to respect, and self-orchestrate who their confidants/friends would be. The budding concept of friendship was bound to the autonomy of the body, as were ultimately all the acts of privacy that the West takes for granted, such as having a bank account, eating alone, or taking a solitary walk.