Health personnel caught between conflicting medical worlds

An example from Java

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Anthropologists are continuously confronted with the multifarious manifestations of ambivalence. In their study of cultures and societies they have been prompt to observe a wide gap between what people say and what people do, and to notice the many ambiguities in human behavior and thought. However, limited by their Enlightenment past and its concern for rational, univocal explanations, they have not always been able to represent the ambiguity of social phenomena (cf. Levine 1985: 8-9).

The same bias is often reflected in medical anthropological studies. Although, as Van der Geest notes in the introduction, human beings experience pain and disease with ambivalent feelings and insecurity, medical anthropologists have been reluctant to indulge in this diverse multitude of, at times conflicting, realities and have preferred to provide single meaning interpretations. Especially studies of traditional medicine have presented static and uniform pictures. For example, accounts of patients behaviour in pluralistic medical situations initially described patients as committed to only one tradition. In correlational models, patients were classified into categories according to socio-economic classes and levels of education, and then related to specific patterns of health-seeking behaviour. It was argued, for example, that patients with a higher socio-economic and educational level were 'supporters of biomedicine, while patients with a lower socio-economic and educational level kept to traditional options (e.g. Gould 1957). In other words, an inherent coherence was implied in peoples choices. Only in the 1980's, anthropologists started to pay attention to the fact that patients had mixed feelings about available medical options, chose them with inconsistency and used them interchangeably (Kleinman 1980). Last (1981), in a study of Hausa people in Northern Nigeria, went as far as to

argue that 'not-knowing' constituted an important aspect of medical knowledge and practice.

Uniqueness and clarity have been attributed to medical specialists. Some authors have regarded them as loyal representatives of their medical tradition, who only approve of those views that are part of their tradition, consequently rejecting any extraneous belief. Other authors have opposed such opinion and have stressed the healers syncretic character, arguing that healers in pluralistic medical systems have integrated various types of therapies from different medical traditions in their services (Van der Geest & Whyte 1988).

It could however be asked whether these two contrasting attitudes exclude each other. In this paper, I will show that this does not need to be the case and that people engage in seemingly contradicting activities. My argument is grounded in the observation[2] that health workers in rural Central Java, Indonesia, relate to other medical traditions in an ambiguous way: while in their professional life they oppose any kind of integration with traditional medicine, in the private sphere they make generous use of it. After describing this 'schizophrenic attitude, I will relate it to biomedicines ideological conflict with the Javanese medical tradition.[3] I will argue that health workers are caught between these contrasting traditions, between the exclusiveness of the medical tradition they are representing and the allegiance to their specific cultural heritage.

Health workers rejection of the Javanese medical tradition

Physicians, nurses and other health workers in Central Java[4] are well aware that the services they provide are only one of the many options available to their clients. Besides biomedical facilities, patients have access to a multitude of healers and therapies belonging to the Javanese tradition. These indigenous options can be classified in two broad categories. The first category includes secular and technical options, application of *ilmu lahir* (outer, technical, natural knowledge) such as self-medication with herbs and massages, and healers such as midwives (*dukun bayi*), masseurs (*dukun/tukang pijit*) and herbalists (*tukang/penjual jamu*). All these specialists use technical methods and so do lay persons when they perform self-medication. Although these methods may include prayers, they do not require the assistance of spiritual power or supernatural entities. The second category includes healers who apply *ilmu batin* (inner, spiritual or magical knowledge) such as 'wise' persons (*orang tua*) and mediums (*dukun prewangan, dukun kebatinan*). The treatments used always involve the *batin* (inner) power of either the healers or their supernatural assistants, although they can be combined with technical practices, such as massage or herbs. To be able to carry out these kinds of treatment, the specialists must have a knowledge

which goes beyond a rational understanding of the material world. They need intuitive inner feeling (*rasa*), and knowledge of the spiritual, intangible aspects of reality. To receive this knowledge, and in turn their healing power, these *dukun* have to meditate, fast and perform mystical acts (Sciortino 1988).

Despite the richness of indigenous medical options, health workers in their official role do not make any effort to integrate or approve them. They do not bother to use traditional remedies in their services and when performing as medical specialists they look down upon healers from the Javanese tradition. Interviews with health centre physicians, nurses and midwives taught me that they regard these options as an expression of superstition and ignorance. When interviewed, they claimed that traditional practices have no value and are relics of the past not deserving any place in a modern society. Furthermore, they argued that traditional therapies and healers should be banned. In their view, *dukun* are dangerous to peoples health. Patients who need biomedical treatment come to the health centre too late, because they first turn to a *dukun.*

Physicians and paramedicals further laughed when confronted with stories of villagers falling ill because of sorcery or spirit possession. They considered them 'superstitious beliefs. According to the health workers the evidence of organic functioning has superseded these beliefs, proving them unsound.

Secular remedies and specialists for the treatment of common natural ailments were also not exempt from criticism. They were considered dangerous, and only reluctantly integrated, when requested by national policy. For example, health workers argued that *tukang pijit* are dangerous, since their massages cause swellings, and that to apply *kerokan* (a massage with a coin to cure influenza and other respiratory diseases) ruins the skin and the blood vessels.

Similarly, cooperation with and training of *dukun bayi* is seen as a waste of time. Health workers must work with *dukun bayi,* since it is stipulated by the national programme, but they still claim that it is impossible to educate them about biomedical notions of health and hygiene. Midwives and nurses alike complain that *dukun bayi* are unable to understand biomedical notions: "No matter what they are taught, they continue using their dangerous methods and rituals during pregnancy and birth. " Some even go as far as to hold *dukun bayi* responsible for the high incidence of infant mortality and argue that *dukun bayi* should not be allowed to practice. Moreover, they claim that people who prefer the *dukun bayi* to their practices are *bodoh* (stupid). Every midwife (*bidan*) has a story to tell about the 'irresponsible *dukun bayi* which more or less corresponds to the following:

> I saw a child die because the *dukun bayi* did not use sterilized instruments. He was all blue. We give to the *dukun* scissors, bandages and instruments to help

them to do a better job. But they do not listen and still cut the umbilical cord with a piece of bamboo. This causes infections and many children die.

For the health workers, Javanese healers and therapies are just the practices of people who have been left behind in the modernization process (*tidak maju*) and who do not yet appreciate the benefits of biomedicine. They argue that once biomedicine has reached everyone, traditional practices and beliefs will automatically disappear. Biomedicine will triumph, since its superiority to local medical traditions will become evident as a matter of course and patients will no longer look for outdated traditional treatments.

Health workers acceptance of the Javanese medical tradition in the private sphere

This manifest public behaviour does not imply however that in their personal lives health personnel refuse the Javanese tradition with equal clarity. As previously argued, none of the observed physicians, midwives and other health personnel used traditional remedies in their practices, referred patients to *dukun*, or talked positively about traditional remedies. But, interestingly enough, all of them made use of Javanese options privately, either for themselves or for their relatives. *Tukang pijit* were consulted regularly for massages in the first stages of respiratory diseases and *dukun bayi* had assisted many female health workers during the delivery of their children. Even the midwives, who often showed animosity against their traditional colleagues, admitted in informal conversations that they too had used the services of *dukun bayi*. *Kerokan* and herbal remedies were also quite popular among health workers, with 85 percent using them (cf. Salan 1991: 10-13).

The following case illustrates the type of relationship biomedical workers have with practitioners of other medical traditions. It is one of the more extreme examples of their ambivalent attitude towards traditional medicine:

> Asked about Javanese medicine, Bu S, a health centre nurse, explained that with the exception of some herbal remedies, she did not believe in it. She even made fun of it saying that all villagers when they have liver problems think that there is a *roh* (spirit, ghost) in their stomach. Further, she declared that she did not know anything about spiritual healers: "It is just popular superstition." When I said that I heard that people appreciated her husband as a spiritual healer, she smiled and went on talking about something else.

When my assistant and I were at her house observing her private practice, two men came in. While waiting for the husband (Pak K) they explained to Bu S that their brother had had an accident and was now in coma at the hospital. Their mother had told them to go to Pak K and ask him for water. Pak K, who had been called from his work, came in and said: "I can ask God for help. I am only a messenger. We must pray together." Then he went inside the room and prayed. He came back, gave the two men some leaves and a glass of water and said: "Put these leaves in the water and place them on the breast of your brother. The two guests thanked him and left. Pak K went back to his work.

> Meanwhile, Bu S went on examining her patient. When she had finished, she explained to us: "I never get involved with Pak K and his treatment. If there are people who want to be treated by him, I do not want to know. If people come to him they want leaves, water and prayers. One time a patient came with a swelling. The patient thought it was *guna-guna* (sorcery) and Pak K thought so too. He ordered the patient to pray and to fast. He then gathered some leaves to give to the patient. This patient would never have come to me, since a nurse cannot cure *guna-guna* I cannot see *guna-guna.* I would only say that it was rheumatism and probably prescribe Dansen or Deksanitason. But the patient did not want drugs. Drugs do not cure *guna-guna.* He needed prayers. I did not say anything. He was Pak Ks patient, not mine.

Trying to understand the reasons of such ambiguous behaviour I continued to visit the health workers outside their work environment. It turned out that they had not abandoned the Javanese medical tradition. As Javanese, they were not able to forget their cultural heritage. Like their fellow villagers, health workers had faith in the Javanese cosmological model[5] and its concepts of health and illness. More particularly, they believed that the universe (macrocosmos) is a paradigm for the human being (microcosm). Like the universe, but on a smaller scale, the human being consists of a container with contents and a centre. The body is a container, which is filled with visible, tangible (*lahir*: outer) elements, such as the organs, and invisible, intangible (*batin*: inner) elements, such as *budi* (consciousness), *nafsu* (passion, instinct) and *rasa* (feeling). The source and regulator of all these elements within the body is the 'soul (*nyawa*: vital energy or *sukma*: the Divine), the centre of the human being. The nature of the soul is constant and is not subject to change by spiritual or physical means. The composition and the distribution of the other elements, and the power that governs them, are however in constant flux. This means that the balance between the container and the contents is always precarious and susceptible to disorder.

The acceptance of this conceptual model leads health workers to regard well-being or health as a state of balance between the body and its elements and to fear the

state of disorder caused by either natural or supernatural diseases, or as they said *penyakit lahir* and *penyakit batin*. The first category includes such diseases as typhoid fever, *masuk angin* (a kind of common cold), *mencret* (diarrhoea) and the like. All diseases are caused either by the improper fit of some natural element in the body, resulting in an imbalance of the body organs, or by the natural degeneration of certain organs. It is common to all these cases that the causes are visible or tangible (*lahir*) and that they can be treated with secular, *lahir*, knowledge and therapies, including biomedicine. The Western medical tradition becomes a kind of *ilmu lahir*, based on the observation of natural phenomena. It is added to the Javanese *lahir* options, without replacing them.

The second category includes such diseases as *guna guna*, *kesurupan* (spirit possession) and the like which are caused either by an imbalance between the power animating the body and the body itself, or by certain supernatural beings, who attack, animate and possess the individual. It is common to all these cases that the causes are invisible or intangible (*batin*) and that they can only be treated by healers with *ilmu batin* who can 'see those invisible causes and cure them. Secular healers are firmly excluded from the treatment of these diseases. The relationship of people with their social and supernatural surroundings is relevant in this context, since disease is considered the result of disharmonious social relationships or disharmonious relationships with supernatural beings due to people's negligence of taboos, customs and rituals (Suparlan 1978, Rienks 1981, Sciortino 1988).

In view of this set of beliefs, it is not surprising that health workers when preoccupied with their own health or the well-being of their relatives deal with the related insecurity and anxiety using their cultural framework rather than their professional one. To interpret diseases in the family they recur to their indigenous cosmological model and search for traditional solutions. If they define a disease as *penyakit lahir*, the health workers try secular options, either biomedicine or Javanese remedies. But if they believe that the disease is *batin* they will not hesitate to consult *dukun* with magical or spiritual knowledge. They know that as biomedical specialists, they have no access to this type of diseases, since they do not master the 'inner knowledge. As a matter of fact, the same nurses and physicians who in the health centre laughed at people's stories of spirits and sorcery, openly spoke about their own personal experience with supernatural phenomena at home. It soon became clear that either they or their relatives had more than once visited a *dukun* to be cured of *guna-guna* and *kesurupan*.

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How should we explain this paradoxical behaviour of health workers who privately use traditional remedies, while they reject them in their formal roles? One possible explanation could lie in the exclusive character of biomedicine (not allowing for integration or acceptance of extraneous elements) and its inherent conflict with the Javanese medical tradition.

The biomedical reduction of the human being to physiological and chemical processes, precludes any 'supernatural' explanation of disease. 'Invisible elements are not regarded as possible causes of diseases since they cannot be validated in a scientific way. Following this line of thought, it soon appears that *ilmu* acquired by meditation, or mystical practice, not being based on observation and experimentation is not recognized as medical knowledge by biomedicine.

In other words, medical traditions that are not based on the cellular view of the human body, as the Javanese one, are ideologically refused by the biomedical model. Similarly medical practices that do not aim at altering the pathogenic cause of disease are considered 'superstitious' beliefs with no scientific foundation and are consequently dismissed. The biomedical model offers very little space for the ideological acceptance of traditional medicine, especially as far as its spiritual, inner component is concerned. Elimination of, rather than cooperation with traditional medicine seems logical from a biomedical point of view'.

Consequently, when health workers apply biomedical knowledge they cannot help but reject other medical traditions. If they want to work effectively as a representative of the biomedical tradition, they have to confine their beliefs to the private domain and only recurr to them for their own benefit. To avoid being torn by conflicting views and paradigms health workers have learned to live with ambiguity and to segment their beliefs according to the social environment wherein they act.

Conclusion

I have shown how the Western medical tradition is in ideological conflict with the Javanese one, and how this conflict places health workers in the rural area of Central Java in an uneasy position, compelling them to hold an hostile attitude towards their own cultural heritage in their official role.

However, this public denial of traditional medicine does not imply that biomedical workers are not affected by the pluralistic character of the medical system wherein they act. In their private lives they are not immune to the fascination of other forms of medicine. It seems that as soon they put aside their provider role, they share the ideas of the 'normal villagers. They shift from an exclusive to a complementary

model. An ambivalent behavioural pattern appears, wherein health workers denounce traditional remedies in the occupational sphere and gladly accept them in their personal lives.

I have argued that health professionals in pluralistic medical systems do not necessarily hold a definite opinion about other medical traditions, either rejecting or accepting them. People engage in 'contradictory' behaviour and unify opposite views and practices, without perceiving them as incompatible.

This exploration of ambiguity underscores Klaas van der Veen's plea for the study of paradoxical and contradictory elements in society. At the same time, I am aware that I am still inclined to systematize social phenomena and to understand them by relating them in an univocal way. This brief essay has been an attempt to avoid intellectual chaos by presenting contrasting patterns in an orderly manner. Whether such an approach is indeed apt to analyze and represent ambiguity is a question about which anthropologists wholeheartedly disagree.

Finally, if it is true that words and sentences admit more than one interpretation, as Levine remarks (1985: 8), then I hope that this essay, besides offering an interpretation of social reality, will also communicate my admiration for Klaas van der Veens work, my gratitude for his support during my study and thereafter, and my best wishes on the occasion of his retirement. I hope our friendship will continue, unambiguously.

Notes

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1 The opinions expressed in this paper are those of the author and do not necessarily reflect those of the institution with which she is associated.

2 The material was gathered between August 1989 and October 1990 during research on the role of nursing personnel in the rural health services of Central Java (see further Sciortino 1992).

3 'Javanese' is used here to refer to the indigenous medical tradition and not to the ethnic origin of the medical specialists. Moreover, although I use this term to name the indigenous medical tradition, and later to refer to indigenous ideas of health and disease, I do not want to imply any general uniformity of ideas and perceptions throughout Java. I think there are some common themes, but I am aware that they are elaborated with great regional diversity.

4 I should emphasize that my aim here is not to give a complete description of traditional medicine and indigenous ideas of health and disease. These subjects shall be discussed only

in as far as they are directly relevant to my argumentation. I refer the interested readers to Geertz 1960; Talogo 1980; Iskandar 1981; Rienks 1981; Wibono 1981; Boedhiartono 1982; Nillissen 1983; Yitno 1985; Rienks and Iskandar 1985; Jordaan 1987; and my own previous study, Sciortino 1988.

5 About Javanese cosmological ideas see Geertz 1960 and Koentjaraningrat 1960, 1988.

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