

‘Tomorrow comes when tomorrow comes’: Managing Aboriginal Health within an Ontology of Life-as-Contingent

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ABSTRACT

The authors have worked in Australian Aboriginal communities within the Wiradjuri area of central-western New South Wales. Examining what appear to be distinctive Aboriginal approaches to time, we argue that these stem not from a different notion of time as such but, rather, from the relationship between the social and the self which places a distinctive value on the use and management of time. One way to access the dynamic between time and self is to realise that life is understood as fluid and contingent rather than predictable. This continually subverts the idea that time is measurable and controllable; that life is lived within domesticated sedentary space; and that planning ahead and self-discipline are virtues. Yet these are notions central to practices associated with contemporary health care. A majority of health care providers, whether Aboriginal or not, are trained in the Australian mainstream health system and may consequently underestimate the implications of different ways in which a person acts on the temporal/spatial dimensions of her life, and how this influences ways in which she manages time in relation to her health and well-being. Temporal concepts, such as ‘planning’, ‘discipline’, ‘future’, ‘boredom’, or ‘patience’, as well as that of the ‘long-term’ with regard to managing illness or money, interact with the ways in which Aboriginal people experience themselves as ill or in need of health care, influencing how they act on medical advice. We argue that the key to understanding the use of time lies not in the concept of time per se but in what is involved in developing a responsive social self when the time/space dimensions of the day to day are informed by a fluid and thus contingent ontology of that day to day.

Key words: indigenous, health, contingency, ontology, social self

INTRODUCING THE ISSUES

We have worked in neighbouring Aboriginal communities within central and central-western New South Wales which are historically and culturally similar: Gaynor Macdonald with Wiradjuri communities since 1981 and Daniela Heil since 1998 with members of neighbouring Ngiyampaa groups resettled into the north-west of Wiradjuri country in the 1940s. Both Wiradjuri and Ngiyampaa people refer to themselves as Kooris, Aboriginal people or blackfellas to distinguish themselves from non-Aboriginal people (Gubbas, or whitefellas). This part of New South Wales was colonised from the 1830s. By the 1880s few Aboriginal people were able to sustain independent economic activity in the face of changes wrought by the introduction of sheep, cattle and agriculture. Once a valued rural labour force in the pastoral and agricultural industries, Aboriginal employment opportunities have declined with the increased use of mechanisation. This has been exacerbated in recent decades by a sharp slump in the rural economy. The majority of Aboriginal people in the region are

dependent on government subsidies and social security payments. Wiradjuri and Ngiyampaa people continue to live on small residential reserves established by government in the late eighteenth and early twentieth century, some of which allow for small-scale domestic agriculture. Increasingly, in particular over the last three to four decades, Kooris from these reserves have moved into adjacent rural towns. Local Aboriginal populations clustered around such towns average between 200 and 800 in this region. They may represent between two percent and 45 percent of the total town population, depending upon the economic viability of the town itself. In tough times, they are more likely to stay while non-Aboriginal people move out. As jobs have been hard to find, motivation for education has declined. Along with the experience of poverty and boredom come increasing health problems. While mortality rates are not as high as in remote Aboriginal communities, they are still much higher than among non-Aboriginal Australians, contributing to the average 20 years difference in life span.

Practices in which Australian Aboriginal people in central and central-western New South Wales engage often appear to work against the interests of their personal health; that is, the well-being of their bodies understood in conventional biomedical terms. When the demands of social engagement, responding to other people's demands, conflict with those of the sick body, it is common that the social wins out. It is not, as is often expected amongst health professionals, the needs of the sick person's body which take priority. While this may be true of sick people in various contexts, we argue that the particular ways in which Aboriginal selves are constituted through social practice means that it is common to observe only intermittent compliance with, or even the ignoring of, the advice of health practitioners — even when this advice is well-understood and valued by a patient. What we have found distinctive to social practice is the way in which these Aboriginal people manage their lives so as to allow for their implicit awareness of its contingent nature, what we will refer to as an ontology of life-as-contingent. Flexibility is required in prioritising the social demands that arise in the course of each day, each one of which demands a degree of responsiveness that cannot necessarily be known in advance.

The anthropology of contingency is not an area that has received much attention. The notion of contingency is often encountered in contemporary debates on risk and risk management but anthropological interest in the implications of contingency is not well developed (although we discuss exceptions below). Awareness of life-as-contingent cannot be reduced to the taking or managing of risk. Rather, we argue that it can be understood as a life within which a person is continually required to be responsive. People are socialised into a disposition that makes them ready to respond to others or events so as to be able to maximise material and social opportunities presented, or minimise unwanted demands. This engages each person in an ongoing negotiation of his self in relation to each of the specific others he encounters through the course of his day. We illustrate *the significance of contingency* in the negotiations of relatedness, drawing on the practice of 'demand sharing' (Macdonald 2000; Peterson 1993, 1997) to demonstrate how the demands of social life impact on the constituting of self, personhood and body. This then helps to clarify how an apparent ambivalence or even irrationality in decisions regarding health care practice can emerge from ways in which these Aboriginal people manage time, as one among various resources in the negotiation of their personhood and valued social relations.

Conventional strategies of health care are often not compatible with the requirements that social responsiveness demands. As we will show, appreciating the reasons for the tensions goes part way to identifying *and* proposing more appropriate strategies for providing culturally secure, appropriate and competent health care for Aboriginal people. In New South Wales, and this includes the state's health department, training in cultural competency awareness for non-Indigenous medical service and health care providers has become integral to service delivery and the application of medical recommendations to Indigenous people. However, whilst it is now considered crucial to recognise Indigenous/non-Indigenous

cultural differences in the delivery of culturally secure and competent health care, understandings of the significance of life-as-contingent have not been well understood. It was in the course of our exchanges about these issues that Heil recounted the conversation that gave rise to the title of this article:

Yesterday, Kevin said to me, 'I will have to be at the office tomorrow morning at 8 am'. With some humour, knowing how rarely he arrived at work early or on time, I responded with an ironic, 'Really?' He humorously retorted, 'You shouldn't ask that question — you know how we deal with time! Tomorrow comes when tomorrow comes. Will I get there at 8am — who knows?'

There is a wealth of meaning in this statement. Unpacking it will reveal what it captures about ways of understanding the self, sociality, time and future. For Aboriginal people, not only Kooris in rural and urban Australia but throughout Australia, negotiating multiple cultural differences creates disjunctures for the ways in which they understand and negotiate daily life, including those contexts in which they make their decisions about the health of their bodies. In turn, these reveal ways in which people act in relation to biomedical understandings and the biomedically-framed demands of their sick bodies.

TIME AND CONTINGENCY

Asad's (1993) injunction that we pay more attention to how people confront the unpredictable, aleatory quality of experience invites new ways of bringing time and contingency into ethnographic analysis. This also opens up new ways of addressing issues that are related to Indigenous health. Not only does this assist in examining specifically Aboriginal practice, it also illuminates the intercultural experiences of people who are dependent for much of their health care and medical service provision on health professionals and policy makers trained for non-Aboriginal cultural and social contexts. And not only are these contexts different, but the models on which they are based do not adapt easily in their confrontation with communal dynamics and cultural practices either. Different approaches to time, interacting with different notions of personhood and sociality, create intersections of both commonality and difference in meaning and practice. We are not arguing here that Aboriginal people in this region have different understandings of time. Although they frequently refer to 'Koori time' as different to whitefella time, it is a difference of use and value rather than understanding. As Munn (1992: 104, emphasis added) has argued, 'time-reckoning in general is constituted not merely in the conceptual reference point or codified system of timing but also in the actor's "*attending to*" such a reference point as part of a project which engages past and future in the present'.

By identifying Aboriginal practices and the ways in which these engage past and/or future in relation to issues of health, we explore the relevance of how people attend to time and thus the ways in which their decisions reflect their understanding of life-as-contingency. In particular, we highlight the importance of understanding *the relationship between* the planned time characteristic of medical advice, and a contingent approach to planning and thinking ahead. From a Koori perspective, life-as-contingent means that time is a-linear and dynamic. In order to maximise the social and economic opportunities which present themselves throughout a day, they need to be continually responsive to context and change. This also implies, although we do not explore this here (see Macdonald and Heil, forthcoming) that boredom is significantly debilitating as well. Poor health is often linked to boredom in disadvantaged communities because life lacks the social dynamic Kooris expect of it.

Time is a resource for both Anglo-Australians as well as Kooris but it can be a resource employed differently to attain different results. The key notions in the use and management of

time for Anglo-Australians are measurement, discipline, linearity and order; in other words, time is something to be harnessed, measured and accounted for in terms of pre-determined outcomes and values. For Kooris, time needs to be treated as flexible and negotiable in order that they may respond to the immediacy of life-as-contingent. Kooris may desire the same outcomes, but their ways of achieving these are not as amenable to a pre-determined timetable because the paths to achieving outcomes are subject to social pressures which cannot be known in advance. Thus they are less likely to have a linear approach to achieving an outcome. As Aboriginal people in Murrin Bridge or Cowra might say, who knows what might happen between now and 8 am, when Kevin might or might not get to work. There could be visitors, or a relative could be sick, Kevin might sleep in, or it might be pouring with rain and he may not feel like getting wet. In other words, there may any number of interventions which make it less desirable or feasible to be at work at 8am or, conversely, desirable to be even earlier (the visitor could be his mother-in-law). Anything could happen – and that is the point. What Kevin captures in his statement is that it is common for Kooris to think about life as inherently unpredictable and full of potential demands which require a response. It is not that life is unstable or chaotic but, rather, that it is understood that contingencies are *always* present and one must be alert to them and re-prioritise if necessary.

A few more comments about contingency and its relationship to risk are in order here. The interest in risk in social research (for instance, Beck 1996, 1992; Boyne 2003) opens up the anthropology of contingency as a way of understanding ways in which people play off the present against their understanding of the future. Two studies in which this concept has been central illustrate both its use in analysis and the similarities and distinctiveness of our own approach. The first is Malaby's (1999: 142) work on gambling in Greece in which he refers to the 'politics of the contingent', equating it with 'the continuous struggle over accountability'. For Malaby, 'the engagement of chance that people experience as they account for the unforeseen from moment to moment brings us to the heart of a theoretical dilemma: the tension between structure and action'. Malaby's subjects' understanding of time as a constant flow understands the contingent as an unforeseen or unexpected interruption to that flow. In contrast, Kooris are more likely to understand the 'flow' of time as anything but smooth to start off with. The contingent event is not an interruption. It is far more likely to be an opportunity. It is life itself (life as a flow of time) that is not smooth and shouldn't be. Its inconstancies, inconsistencies, opportunities and surprises require that one be ever vigilant for what it may bring. Being 'on the lookout' for the contingent is the norm; in other words, tomorrow could bring anything. The expectations and demands of social life are structured around an understanding of the contingent in the quotidian as part of the constantly fickle flow of life. In this conception, the structure/action relationship has to be reconceptualised: they are in a yin yang relationship rather than one of opposition.

The second is Bledsoe's study of the experience of women dealing with pregnancy in Gambia. She worked with women who used contraception in order to space out and therefore enable more pregnancies because the spacing allowed their bodies to recover better. However, they were thus subverting the reasons for health agencies providing the contraception, which was aimed at reducing the birth rate. A key principle in Bledsoe's (2002: 24) argument is that these women 'try to manage or contain the effects of deleterious events' [becoming pregnant before their bodies have fully recovered from the previous one] by establishing 'contingency plans' which will enable them to have more and healthier babies. Bledsoe's (2002: 25) notion of contingency

implies randomness, uncertainty, and risk. It also implies a sense of vulnerability and a sense that the wearing effects of harsh ordeal can have cumulative effects. ... *contingency* in the sense of containment also implies a capacity to take action to check harmful repercussions of events, especially through cultivating social ties with those who can help in a crisis.

Her use of the term has similarities with that of Malaby. What is uncertain is 'risk', what needs to be controlled for is the deleterious (Bledsoe 2002: 22). The logic of contingency is attended by implications of cumulative susceptibility to proximate (negative) forces. When referring to people living with fragile and mortal bodies, bodies worn out by pregnancies, Bledsoe's analysis is powerful and relevant. Like Malaby, she uses the notion of contingency as an untoward, as an undesirable interruption, as requiring an ordering response.

Aboriginal Australians have long histories of hunting and gathering in unpredictable ecological environments, where seasons have only approximate predictability, and where rainfall patterns are precarious. It is not the fragility or health of the human body, as in Bledsoe's study, but the material and social environments to which people must be able to respond, drawing on what those environments offer as each opportunity presents itself. Even for those Aboriginal people whose lives have greatly changed, as is the case for Kooris in central-western New South Wales, this remains a dimension of their ontological understandings of their selves and their relations to others. In this situation, the cumulative tendency of which Bledsoe speaks is neither apparent nor relevant. The environment, and the conception of human/spiritual life within it, is enduring but also fickle and demanding. It does not allow for a lineal view of time, or the short or long-term planning made possible by a conceptually and ecologically more stable world. And in a fickle material environment, social relations must be kept strong. They are not taken for granted and must be continually reinforced to stay healthy and dependable so as to provide the maximising of or protection from whatever each day brings.

In common with the situations described by Malaby and Bledsoe, we also aim to understand how people make decisions about the relationship between their present and future. But the starting point for Kooris is not to order or organise in order to overcome the contingent. Rather it is to appreciate that the fickle and labile character of everyday life is the norm; the contingent is the norm, the anticipated and even the desired. Both in the past and in their ever-changing present, Aboriginal peoples have long had a need to be alert to opportunities *as they arise*. It is not so much that the *opportunities* are unpredictable as the *timing* of them. It will rain but one cannot say when. Visitors will arrive but one cannot say who or when. Aboriginal peoples are now dependent on fickle government policies rather than hunting and gathering but the dynamic of contingency remains, in the midst of much change, an integral part of the constitution of their personhood and social engagement and the way they act in time. To plan for the future with any degree of commitment contradicts the need to be responsive to events as they occur. It may deny people the opportunities the not-yet-known may present — opportunities to augment resources, to provide valued social activity, and so on. The need is not so much to *avert* risk or misfortune; it is not, as in the case of gambling (which is a favourite Aboriginal pastime) a hedging of bets about the future. Rather, the need to be vigilant is to enable responsiveness, to make the most of opportunities, social and material, that may be 'around the corner.' It is to be open and alive to all that life might offer. The major difference between our understanding of contingency and that of Malaby and Bledsoe is that both authors confine the dynamic of contingency to *containment*. We are interested in contingency as the maximising of opportunities: *contingency* as *opportunity* rather than one defined in terms of averting misadventure or dealing with the unanticipated in what ought to be a smooth flow of life/time. We draw on this model of life-as-contingent and thus as replete (ideally) with opportunities which must not be missed, to demonstrate the ways in which Aboriginal peoples prioritise decisions which impact directly or indirectly on their physical (bodily) health.

With these ideas in mind, and conceptualising Munn's notion of 'project' mentioned above in a generalised way, we argue that Aboriginal people's projects, when engaging the past and future, will seem to privilege immediate social demands. This means at times, from the point of view of health practitioners, that this may be to the apparent detriment of their long-term personal well-being. Social demands, as immediate opportunity, frequently create disjunctures for the healthy body as long-term project.

ABORIGINAL UNDERSTANDINGS OF 'HEALTH'

As anthropologists such as Myers (1986), Sansom (1980, 1988) and Heil (2003; in press) have elaborated, Aboriginal personhood is developed from an understanding of a social self, a self constituted in relationship, quite literally before birth, from his or her conception. They are born into a kin-oriented world which will shape interaction throughout their lives. While the intensity of kin-relatedness has somewhat attenuated for Wiradjuri and Ngilyam-paa through their colonial circumstances, personhood is still overwhelmingly constituted by a sense of personal autonomy. But this autonomy can only be constructed out of relatedness: it is not separateness, as implied in the notion of monadic individualism. The implication of this ontological perspective is, first, that being in relationship is the primary measure of 'being well', whether understood as personal (physical/mental) or social well-being (see also, Parsons 1985: 90). The measure of one's life is counted in terms of the strength of social networks (cf. Macdonald, in press) and the resources of knowledge and opportunity these open up. It is thus social relatedness in which time and other resources are primarily invested.

Second, it implies that the wellness of one's physical body is measured by the extent to which its state of being enhances or impedes social interaction. One might be 'ill' according to a medical practitioner but able to continue with all of one's valued activities, in which case an Aboriginal person might see him- or herself as 'well' (Heil 2003). The same person will describe themselves as 'sick' when unable to engage socially, irrespective of a medical diagnosis. 'Sick', for instance, can include 'sick from the grog', minor or major ailments, being 'out of sorts', or not wanting to participate because of conflict (see Macdonald 1995).

Illness is part of life, as is joy, as is conflict, as is celebration and death. One has to 'roll with the punches'. To ask a Koori, 'How are you feeling?', might prompt responses such as, 'Oh, as good as can be expected', 'Could be worse, I suppose', 'No use complaining', 'Oh, you know how it is', or 'Good and bad, the whole lot'. Within such comments is an acceptance that life cannot be expected to be the idealistic state of complete physical, mental and social well-being of the World Health Organisation's imaginary. Their 'narratives of convergence' (Morris 1998: 13) do not look to a notion of perfection. Nor do they expect life to be free of conflict, predictable or stable (see, for instance, Macdonald 1995). As Morris (1998: 241) argues more generally, the absence of illness is not a necessary condition for health, and his critique of the health-illness dualism that doesn't allow for anything other than good health or sickness is particularly pertinent in the Aboriginal context.

Thus our analysis here implicitly draws on our engagement with the work of critical medical anthropologists such as Lock (2002; 1995; Lock and Gordon 1988; see also, Lock and Farquhar 2007; Scheper-Hughes and Lock 1987) whose work challenges the epistemology and universality of assumptions underlying the theory and practice of contemporary mainstream Western medical practice. This includes the social power inherent in its hegemonic institutions and discourses. Scheper-Hughes and Lock (1987), for instance, deconstruct the ways in which mind and body have conventionally been conceptualised, and Adelson (2000a, 2000b, 1998), addressing this in a non-Western context, places particular emphasis on the cultural background and constitution of health, sickness, identity and what it means to be well. Like Adelson, we explicitly aim to unsettle the relationship between health and illness, and the individual person. Rather than looking at individuals and their society, we examine an Indigenous cultural context within which personhood as well as well-being are constituted *socially*.

Although there is a long tradition of research into Indigenous understandings of sickness, the paradigms underlying these studies have invariably used the biomedical model as a reference point. Morris (1998) breaks this nexus between health and bodies. His position is radical in that he separates the understanding of sickness as a physical or mental condition from that of health arguing that people can understand themselves as healthy even with

illness or disease. For instance, Bell (1983: 147) in her study of the Walpiri provides an example of children becoming sick because police had been shooting camp dogs, unaware that these were totemic animals for children. Most Australian Aboriginal people *expect* illness to be an outcome of *social unease* as when people break tribal laws. From early records of illness among Wiradjuri people, it has been recognised that, in common with Aboriginal people throughout Australia, sickness was understood to be caused by *external human* forces (see, for instance, Beveridge 1883: 35; Mobbs 1991: 303), as in sorcery. Although no longer explicitly linked to sorcery, malignant spirits or humans as in the past, Kooris often tend to conceptualise illness as an external force acting on their bodies and their matrix of social relationships (see also, Myers 1982, 1986). However, they do distinguish between minor illnesses that are considered a normal part of everyday life and serious illnesses that are disruptive of a person's life, which render it out of their control. The latter are illnesses which mobilise a person's whole family, possibly even unsettle the whole community.

People who are seriously sick in central western New South Wales usually have to be sent to hospitals which may be hundreds of kilometres from their rural community. Occasionally, a car or bus load of people might be organised to go and visit sick relatives so as to provide them with the social reinforcement they are unable to seek, or practise, themselves because of their illness-related absence. Sansom (1982) has observed that there are symptoms of certain illnesses which compel the family members of sick Aboriginal people to help them. As a consequence, the sick person takes on a new social role, which Sansom describes as 'the sick who do not speak'. He argues that sicknesses must leave signs that:

are essential to the creation and perpetuation of relationships of long-term indebtedness amongst a community of people who have no property but rely instead on verbal warranties (called 'the word') to carry indebtedness over from the past into the present and so to transform local fields or networks of social relationships by locating obligations of enduring indebtedness within them (1982: 183-4).

Sansom's observations are important. The Aboriginal 'self' is constituted in *active* engagement with significant others and appreciating this helps to explain why decisions about health care practice are always contingent on what is going on in a person's world at a specific time. There is an immediacy about decision making which can often conflict with expectations of the broader society and its health care system, one which expects that people can and should put their 'selves' at the forefront of decisions made about personal health and well-being.

What looks like an apparent inconsistency on the part of the individual Aboriginal person as 'patient' may be consistent with the patterned way in which that person is known to make life choices on a daily basis. Those life choices are, in a cultural tradition which privileges the social over the individual, ones that take account of the need to engage in certain social interactions in order to remain 'in social credit' with significant others. To focus on the needs of the unhealthy body might seem at times to require a rejection or subversion of the social body, and thus increase the fear of potential social isolation. At other times, one's 'sick' body may enable or enhance such opportunities, through encouraging the indebtedness of which Sansom speaks. It is this that makes the notion of time as contingency important to an understanding of how health-related decisions are made, and why they are hard to predict.

THE DEMANDS OF THE HEALTHY SOCIAL BODY

The pressures on Aboriginal peoples to be socially involved which impact negatively on personal health care give rise to various practices which, from the perspective of Anglo-

Australian health professionals, seem irrational and antithetical to looking after one's health. Another of Heil's encounters will illustrate:

On Thursday Bessie, who is 40 years old, broke her ankle. She was hoping the problem would go away by itself but, of course, it did not. By Sunday, when the pain had become unbearable, she was unable to continue her daily walks through the community to socialise with people and she let me take her to the hospital in town. As the local hospital had no x-ray facility, but it seemed safe to assume that Bessie's ankle was broken, it was put in a supportive plaster that was attached to her leg with a bandage. She was given crutches and the local doctor firmly recommended her to go to another hospital (160 kms away) to get an x-ray done as soon as possible.

The following Thursday, a week after she broke her ankle but the first day they had the money for the petrol, Bessie's relatives took her to the other hospital where an x-ray confirmed the broken ankle. The ankle was put in a plaster cast and the doctor told her that she would have to wear the plaster for three weeks. She told the doctor that she needed to be able to walk so he gave her a special sandal to wear over the plaster. As she told me later, the sandal looked ridiculous and she told the doctor that she wouldn't wear it. Consequently, he then put a 'sole reinforcement', resembling a platform, on the bottom part of the plaster.

Bessie didn't want to 'stop home', risking sitting around all day on her own, getting lonely, and being excluded from everyday routines. She wanted to ensure her participation in the particular 'mob' [how Aboriginal peoples refer to significant others, most usually a reference to kin] she hung around with most days. That meant she was walking around a lot. After two or three days, the plaster loosened and produced blisters on her foot. At the time, 'Doctor's Day' in the community was only once a week and, on the next one, the following Tuesday, she went to the clinic to see the doctor. The doctor took the old plaster off and put on a lighter one, similar to a very strong, slightly elasticised bandage: according to the doctor, 'the latest plaster invention'. The only disadvantage of the new plaster-bandage was that it did not provide any support to enable her to walk. Nevertheless, Bessie wore a sock around the new plaster's foot and continued walking as before.

The next day, in the afternoon she went to have a drink with her friends: one of them had just become a grandfather and, of course, that had to be celebrated. After she had been drinking with them for several hours, with her leg constantly hanging down, the pain in her leg and the pressure of the bandage got worse and worse. Consequently, as soon as she got home, she took the whole bandage off, as, according to her, it cut off the circulation in her leg. In response to my concern, which included telling her that taking this bandage off might ruin her leg for the rest of her life, she replied, 'I'm black, I know what I am doing'.

From my perspective, at that particular moment she wanted to get rid of the pain and was longing for relief. However, for over two weeks now this plaster had been the object separating her from the group she wanted to be with and it had thus prevented her from acting out her social practices in her conventional ways. During this time, other members of the group continued to meet without her, not seeing her injury as warranting visits or a relocation of their activities, and that way increasing Bessie's sense of isolation.

While this example is not typical, in that one could not predict that Kooris would react to an uncomfortable plaster in this way, what is understandable is the fact that Bessie made a decision which was in her social interests, regardless of its impact on her personal health. While such a response is not unusual, it requires an appreciation of the ways in which

Kooris think about life-as-contingent, and the role of the body in facilitating the social (see also, Heil forthcoming). This sheds light on the dilemmas Kooris confront when the demands of social engagement conflict with practices deemed desirable for good health.

Nor should our argument be read to imply that Kooris do not understand the efficacy of biomedicine. On the contrary, they value it highly and have been accessing it for generations. In the context of diabetes, for example, people almost always stick to the medication prescribed by the doctor, the dosage is never questioned. Indeed, there is perhaps too much belief in 'the magic pill' as it can encourage the attitude: 'I can continue to live my life the way I want to as long as I take my medication.' Usually, the ones who stick to their medication are the ones who have accepted that they are sick, whatever their experience of symptoms.

But there are others, for instance diagnosed with diabetes who do not do anything about it and ignore the recommended medication regime. These are the ones more likely to say, 'It isn't worrying me or preventing me from doing what I want.' Diabetes poses a particular challenge for doctors seeking compliance because, from the patient's perspective, it does not produce a sudden or immediately debilitating experience of illness. Together with its many complications, it develops slowly, worsening over a long period. People get used to operating in a certain way, even if not feeling as 'well' or as energetic as previously. The diabetic doesn't experience major differences from one day to the next day, and the medication doesn't necessarily make them 'feel better'. This can work against them taking action on their own long-term behalf if that action is socially or economically debilitating. An ambivalence is created between long term planning, the need to make lifestyle changes, and the immediacy of social life. As Heil recorded:

One man who has problems with his kidneys said two months ago when he had seen the doctor that he won't need dialysis for another six months at least. It was clear he thought about these six months as a definite period; and thus as something he didn't have to worry about in the intervening time. When asked if he had thought about what he might have to do then, that he might, for instance, have to move away from the community as there was no dialysis locally, it was evident that he hadn't given any thought to such an eventuality and it was clear he didn't intend to.

THINKING ABOUT TOMORROW

Aboriginal peoples *do* think about tomorrow. They think ahead to Easter and Christmas, and whether they will have enough money for the kids' presents. But this does not necessarily translate into action between now and then, into strategies which will be prioritised in order to arrive at desirable outcomes. When they say, 'Tomorrow will take care of itself', it is in the belief that, if one is in crisis, there will be people who will provide support, and if there aren't, there is nothing much one can do to change things. If the money isn't there before Christmas, it might be a 'shame job', but there are good years and bad ones. If your relationships are healthy, then auntie might help out. It is an example of what Stanner (1973) referred to as Aboriginal people's assent to life's terms. They expect to work with the contingencies rather than against them, and live with an ever-present appreciation that all future plans are contingent.

It would be a mistake to interpret the idea of 'who knows what will happen tomorrow' as unconcern for what lies ahead or as an indication that Kooris do not think and plan. In fact, they often seem very future oriented, not only in making plans but in their explicit awareness of their own life cycle incorporating both its impacts on the future, on one's 'children's children' and its obligations to the past — to ancestors or 'the old people'. Much

action is explicitly oriented to one or both of these groupings. Nevertheless, it is the present which is the focus of both past and future. It is present action that has been inspired by ancestors or which would, conversely, 'make them turn in their graves'. Likewise, it is present action that will ensure or diminish the ability to transmit certain values, knowledges and practices to following generations.

What is more interesting in Koori expressions of past, present and future is how often the immediate present is seen as precarious. One never really knows what the day will bring and it is in the here and now that one must concentrate one's energies. There is nothing taken for granted in the everyday of Koori life. Perhaps implicitly evoking a hunter-gatherer past in what was one of the world's most fickle environments, the unexpected is still the 'norm' around which people develop strategic and negotiated approaches to life so that they are always ready to respond to what comes their way, to take advantage of opportunities presented or to adjust according to constraints imposed by weather, enemies, colonists and sickness. This orientation, in part perhaps maintained through the vagaries of shifts in modes of colonial governance over the years, also adds a 'spice' to life. There is a valued dynamic in not knowing what will happen next. Frequent references to boredom are often a reflection of the increased predictability imposed by decreases in visiting, the monotony of unemployment (and some employment), being without a car and the petrol to put in it, and more regular social security payments (unemployment, aged and sickness pensions, sole parent benefits, and so on). Unpredictability in the supply of resources is being replaced by government practices which increase but regulate the supply of individualised 'welfare' payments and require stable residence. All this undermines social dynamics because there is less need 'to look out for' others (see below).

The future, and thus intention, is always contingent on a present *and* the time-space between the present and any act planned or outcome desired for the future. Any number of events may intrude and this is expected, normal. It is not a rejection of a relationship or an aspiration to make plans that are not eventually kept — what matters is the intention at the time of making them. Social relatedness is understood in the immediacy of the present and thus the present takes precedence in constituting the social. Declared intention can be used to place a value on a present relationship even where there is little commitment to future action — it works like the 'little white lie' to save face in an encounter, where to say no would be insulting.

Harris (1987: 2-3) illustrates similar behaviour among Yolngu people of northern Australia. He refers to the difficulty non-Aboriginal people have with linking Yolngu verbal commitments to actual behaviour — 'from fishing trips to important political decisions', producing the Yolngu reputation for being subjective and 'living in the present'. He asks:

Is it inexcusable that having agreed to go fishing on Saturday morning, and having decided to change his mind and not go, he fails to come and let you know?

From the Yolngu point of view, No. To begin with, he has done nothing as definite as 'change his mind'. Yesterday when he made the commitment, his intention to actually go fishing was probably serious. However, he wasn't saying 'I hereby agree to take you fishing tomorrow, come hell or high water'. He was saying, 'At the moment, I feel that I'd really like to take you fishing in the morning'. Yolngu tend to be opportunists and to act on impulse in the sense that they tend to be ready to react to opportunities as they present themselves, rather than to carefully plan for them.

At the same time, Aboriginal peoples are capable of extensive and complex organisation and planning. So what can account for Aboriginal people's (non)commitments and (in)abilities in planning ahead? Below we unravel this more explicitly by examining aspects of what it means to be in relationship.

CONSTITUTING SOCIALITIES: DEMAND SHARING AND RIGHTS

The negotiability and contingency of everyday takes place within broader structuring practices and meanings which provide context and limits to the ways in which socialities are constituted. One way of understanding the demands of the social is through the practice of 'demand sharing', which Wiradjuri and Ngiyampaa people share in common with Aboriginal peoples throughout Australia (Macdonald 2000; Peterson 1993, 1997; Schwab 1995) and which is grounded in kin-relatedness. Demand sharing refers to the requirement that one shares material items in one's possession with certain others, such as close kin, when they ask for (demand) them. Items are rarely offered but all people can make demands of at least a certain number of others. This is a system of sharing stemming from what were once hunter-gather economies, which is interesting for the way in which it maintains the autonomy of the asker (receiver) in that they have a right to ask which does not entail indebtedness (there is no requirement to reciprocate, except in respond to like demands made by people in an appropriate relationship) and curtails the power inherent in giving (because one should only respond to demands to share). Demand sharing is a system of distribution that works well in situations of uneven and unequal access to resources (although, contrary to much commentary, not well in situations of scarcity which many Aboriginal peoples face today). These days, common everyday demands are for cash, rides to town in a car, clothing and food. It is rude to refuse and a refusal may even sever a relationship – at the very least, it subjects it to stress and often to conflict. There are, however, a number of socially acceptable ways of refusing, as well as a refined etiquette of 'little white lies' for avoiding requests. Nevertheless, the principle is that, if one values a relationship, one will accede to demands made to 'share' (see further, Macdonald 2000).

Demand sharing makes certain kinds of disciplines associated with the maintenance of personal health very difficult to achieve without negative social impacts. The best example is dieting — a common 'treatment' prescribed for illnesses such as diabetes and high blood pressure. Dieting is difficult because it assumes an individual can and should be able to manage money (to budget) and food (in a domestic economy) over a given period (a week or a fortnight). This expectation, regularly made of most Australians, assumes that desire is individualised, and thus that primacy will tend to be given to the needs and desires of the self or, at most, the immediate family. In a Koori household, food placed in a fridge or cupboard is defined as communal, irrespective of who purchased it. Food one did not want to 'share' would have to be hidden but hiding food is seen as one of the most insulting acts, a denial of the social. Demands for highly valued foods, including fresh fruit and vegetables, mean they have a short storage life. A dieter can buy as much low fat milk, fruit and high fibre cereal as they like but it would be rare for it to last more than a day or two at the most. Such foods are also expensive compared with cheap takeaway foods which are characterised by high carbohydrate, high fat and sugar content. In economically-strained households cheaper foods are an understandable response to the need to feed a family on a low budget, particularly with demands to share extending to kin beyond the household. Although certain kinds of home cooking might be even less expensive, they will depend upon a certain level of basic ingredients (salt, flour, oil) and it is hard to guarantee that these will have a sufficiently long shelf life to enable planning through a two-week or even weekly cycle. As cash is also subject to demand sharing, it can also be hard to budget ahead in the context of demand sharing. The 'success' of demand sharing over a period of time in providing for a family network depends on a sufficient number of people getting access to welfare or wages money at various different times. Otherwise, the household will tend to go through a 'boom and bust' period between allocations of cash.

There are occasionally situations in which people can stay on chosen diets. In one case, a senior working woman lives alone and has only one close relative who drops in from time to time. Most of the time she is able to control what she buys, how she cooks and what she

eats. During holidays, however, when many kin visit, her fridge and cupboards are as vulnerable to demand sharing as anyone else's. These kin are not necessarily aware of her dietary requirements and she may not be able to keep the food she needs separate but negative impacts are short-term. In a second case, also that of a senior woman living on her own, she had 'Meals on Wheels' (a community service for the sick and elderly) deliver her mid-day and evening meals. As this is packaged in one person serving sizes, and daily, it was less amenable to demands to share which might otherwise come from the various children and grandchildren who are constantly backwards and forwards between houses. These women's circumstances allow them to control what they eat to a large extent without the criticism that they are selfish or mean because they are not sharing their food with others. The cost is that they live alone, which few Aboriginal people find either desirable or possible. In both cases, their age and seniority protects them to a greater extent than would be the case for younger women, whether living alone or not. But this protection will only apply for as long as they are able to exercise control over their own lives and incomes. In the second example, this grandmother is an aged pensioner. The impact of the 10 percent consumption tax introduced in 2000 (GST) was severe and led to her difficulty in meeting winter electricity costs, paying rent and Meals on Wheels, and keeping up with social events such as occasional card games. She elected to go without the meal program, which had a significant impact on her ability to control her diabetes. When Macdonald discussed this with her, it was clear she saw her social activities as more important to her overall well-being. Her prioritising, however, could not in any simplistic way be called 'cultural': while the culturally-defined prioritising of the social influenced her decision, the need for the decision was brought about by poverty. The location of hospitals also plays a significant part in how and why people make the decisions they do. Rarely are they within walking range and frequently they are in different towns, compounding the problems of social isolation. The economic and the social intertwine to make the accessing of medical care unattractive and/or unaffordable.

Thus it is also clear that expecting Kooris who are bound into complex and demanding socialities, which are largely maintained through demands that people 'share', to be able to control their purchasing and storage of food over a fortnight so as to stay on a disciplined diet is often unrealistic. The choice is akin to that made by Sal when she decided not to have her cancer treated hundreds of kilometres away in the nearest hospital. Socialities are what make sense of life, not healthy bodies out of kilter with kin and a known world. Other people help one *feel* better as one is still part of the daily round of demand sharing. One can ask for medications such as painkillers, antidepressants, antacids and laxatives; ask people to attend to sores; or ask for cash to enable the purchase of prescribed medication (rarely do prescribing doctors ensure that a patient has enough money to have the script dispensed, so they often aren't).

Demand sharing is an important part of the ways in which sociality is constituted, negotiated and renegotiated all the time. This is still a kin-oriented world in which not to share is not to be in relationship. One must be ready to respond to the demands of others or be seen to be greedy, non-social and risk being isolated. And one must also be able to take advantage of opportunities which present themselves during the course of any day so as to be able to demand desired items or services from others. Nevertheless, these demands pose particular problems for middle-aged and older people who hold strongly to these values even though cultural change and external pressures mean that their younger kin do not always accept the reciprocal nature of these demands and can exploit them at times.

It will be clear that demand sharing is limited to a localised face-to-face social-spatial sphere. Koori sociality is dependent upon face-to-face interactions: only those people who are present can participate. In the constituting of the self through sociality, demand sharing emphasises the immediacy and primacy of the social. The life chances of Kooris are not dependent on the social in an abstract way but on 'presence' — on 'being there' to make

demands and respond to the demands of others. Every day action reflects the desire of people to be continually locating themselves within social contexts. Even close kin relationships are forever being tested and negotiated. There is a constant tension between the autonomy of each person and the demands of social relatedness which require negotiating as each activity or engagement presents choices which must be evaluated and acted on. This takes time, energy and resources. It often seems as if the well-being of one's own body is made subservient to the demands and desires of sociality because not to be present is to risk missing out. At its extreme, it means to be isolated, forgotten — to have become a non-person. To stay away from a community for too long, even in hospital, not to attend the really important occasions such as funerals, or to consistently refuse to share risks isolation and social death. Re-incorporation may take some time, even years.

The notion of rights in such a context, including the rights associated with making demands, can be understood in terms of active engagement. Although one is born, for instance, with rights to land, to access certain age or gender-specific knowledges, to kin-relatedness, these rights are not taken for granted. Rights cannot be claimed unless one *acts* in accordance with the responsibilities and obligations that accompany them: they are expressions of social relationships. To claim rights or make demands, one must be seen to be engaged in the social. If a Koori has moved elsewhere to work, he will need to visit reasonably frequently and his visits will require that he spend quality time with a sufficient number of people so as to be seen as actively identifying with the community. Long absences with little or no contact mean that a person has to take time to be reintegrated before they can have their say in, for instance, meetings and other community affairs. This need to activate the obligations that give substance to rights applies even to kin relatedness. If someone does not behave as a brother should, it is not unusual that his brother would say, 'I'm not giving you anything! You're no brother to me!' Strained relations can only be restored through action, through the performance of the requirements of social relatedness.

THE BODY AS VEHICLE FOR THE SOCIAL

The kin-oriented world of Aboriginal peoples is unfamiliar to many Australians, as well as to the models upon which so much health policy and practice is based, including the context of alternative medical approaches. The mainstream health service in Australia, undergirded by biomedical principles and enacted through health professionals such as doctors and nurses, within hospitals and clinics, implicitly relies on long-standing cultural expectations of social and personal disciplines. It anticipates the regulation of time and the disciplining of the body in various ways: medicines are frequently prescribed to be taken at certain times of the day such as morning or night. 'To be taken three times a day before meals' is an instruction that assumes a pattern such as breakfast, lunch and dinner. Appointments are made in advance to see practitioners; without appointments, and even with them, waiting is common. Many 'lifestyle illnesses' are treated with recommendations that people follow dietary and exercise regimes: they belong to an overall social economy of order, rationality and discipline. Most of the assumptions underlying this system are non-problematic for those used to such disciplinary practices, who have been taught to understand their general quality of life as being bound up with their personal state of physical and mental health, and who understand the disciplining of time and body as a means of maintaining good health (and, implicitly, longevity). This is not to imply that Australians find the demands of health care easy or practical, only that those in the dominant Anglo-Celtic tradition at least are socialised into such disciplines and come to expect these as appropriate forms of personal care, whether in the context of biomedical or alternative remedies.

Most medical practice focuses on the individual's body. In addition, much of it rests on an understanding, as Morris (1998: 14) puts it of the body as a machine, one 'which requires merely an occasional trip to the repair shop', after which, one assumes, it is re-

tuned to perfection (see also Foucault 1975, 1979; Hatty and Hatty 1999; Samson 1999; Scheper-Hughes and Lock 1987). Young (1997) talking about the phenomenology of the body in medicine, refers to the transformation of the body, provoked and produced by mainstream medicine, into the 'body-as-object.' It could be argued, of course, that this is hardly an adequate, appropriate or enabling model for Australians of an Anglo-European heritage. But in the Koori case, it is particularly distorting and dysfunctional because it so often forces a choice between valued socialities and the individualising demands of biomedical 'cures', setting up an unenviable and perhaps unmanageable tension for someone defined as a patient. There is a disjuncture between the expectations of health treatment for a self constituted as an embodied, monadic individual and one in which selfhood is constituted out of the making and meeting of social demands and obligations. The Koori understanding of the self as social subverts the disciplines designed to shape the western self.

In contrast to Anglo-Australian attitudes in relation to the materiality of the body, and the separation of the body (as flesh) and the self (particularly as soul), Wiradjuri people do not fixate on the body as an abstract thing in itself to be thought about as part of what it means to pursue life as an individual. One's own body is yet another medium, as are all objects, through which social relations are expressed, negotiated and shaped on an on-going basis. The value of the body itself is relative in terms of its potential to influence and determine the nature of various social outcomes. A healthy body is thus one which enables the achievement of valued social outcomes. These outcomes have to be understood in a particular context and cannot be assumed in general terms. Thus the body is important for how it enables interaction rather than for what it is in itself, as a part of or a vehicle for an individual self. Mobile bodies enable participation in the 'to and fro' of daily life, so that demands can be made and met. One's body-self changes with the social context, particularly within a hierarchy of social relatedness which is not static but changes with every social constellation, even within a spontaneous clustering of Kooris in the main street.

The Koori person's body understood as part of the self-as-social puts a particular emphasis on social relations and relatedness. Social relations are also understood as a key contributor to individual health and illness. A person's body is seen as a unitary, integrated aspect of self and social relations. It is dependent on, and vulnerable to, the feelings, wishes, and actions of others and is not understood as an independent vast and complex machine that, from a more bio-medically oriented perspective, can be fixed. The morphology of the body is a matter of social not individualised concern (see also, Becker 1995). Because Kooris do not stress a conception of the individual body-self, socio-centric explanations of sickness are also common, such as adverse and wrongful social relations, or the breaking of social and moral codes. These socio-centric explanations of sickness and health have frequently given rise to medical anthropologists' assumptions of an equation between a healthy body and a healthy society on the one hand, and a sick body and an 'out of order' society on the other hand (see, for example, National Aboriginal Health Strategy Working Party 1989). While there is truth in this, it can lead to simplistic analyses and should not be taken at face value, at least not without exploring in depth what is meant by 'the society' or 'holistic approaches' in such an equation. It is not just a matter of improving living conditions or even of promoting 'cultural autonomy', especially when these are not accompanied by extensive economic development programs.

We do not mean to suggest that there exists no Koori notion of one's own body (to distinguish between the 'individual body-self' and a socio-cultural understanding of 'person'). On the contrary, social relationships can only exist if one is present and recognised by others to be present. Hence the fear of loneliness in death, that one will be forgotten because not present. A big funeral, a tombstone, and visits to the cemetery are characteristics of Wiradjuri and Ngilyampaa practices which demonstrate the value of *physical* presence. But the notion of health associated with such presence is not that normally associated with the bodily health required by members of a highly individualised, post-industrialised society

which imputes social values on a basis of achievement in a physically and intellectually demanding labour market. Nor is health necessarily linked to a high value placed on longevity. Rather, health is that state of bodily being which enables one to keep going with valued social practices. It follows that going to hospital may be a socially stressful experience as it also takes a person out of their normal social round.

This means, of course, that there is a radical dissonance between the lifestyle and expectations of a rural Wiradjuri person with diabetes and the educated urban middle class Australian around whom the strategies for cure, control and prevention are designed. There is an implicit expectation on the part of health carers and perhaps a majority of citizens that people are expected to belong, and want to belong, to an ordered, disciplined body-world. Diet and exercise are two of the predominant obsessions of middle-class Australia — indeed it would seem that obesity and lack of exercise increase in direct proportion to the increase in the health food and lifestyle industries. One begets the other in the complementarity of consumerisation. The preoccupation with diet and body shape is evidenced everywhere — on magazine racks, advertising billboards and various health-related televisions and radio programs. Kooris generally seem much less influenced by such propaganda and place far less weight on having a socially-approved body shape or level of fitness. They will usually express far more concern about weight loss than about weight gain unless the latter is truly excessive.

Body shape makes little difference to the quality of their social lives, which depend on the outcomes of their responsiveness to share and their capacity to respond to one another rather than their appearance. Kooris tend not to be self-reflexive about their own body shape, and will chide others who seem too concerned. When they comment on differences observed, such as, 'You've been putting it on a bit, my dear!' the speaker could be obese herself. She is merely acknowledging changes taking place rather than making a moralistic comment. What interests Kooris are *other* people's bodies, eating habits, weight fluctuations (especially if they happen rather quickly) and what this tells them about that person — depressed, menopausal, in love, and so. The body signals news to catch up on. The contrast here is between a focus on the body as disciplined, regimented according to a certain expectation of social life, an embodiment in which body-consciousness takes on a particular significance, and Koori practices which suggest an understanding of the body as a vessel or vehicle for certain forms of sociality, a representative of the social body (as argued by Mary Douglas 1970, cited in Scheper-Hughes and Lock 1987).

ILLNESS IN THE NEGOTIATION OF SOCIALITIES

In trying to understand the ways in which peoples of different cultures, genders and ages respond to cultural and personal understandings of health and illness, there has been a tendency to develop static models, as if people have a singular view which determines how they respond to illness and treatment. The centrality of contingency in so much of Wiradjuri and Ngiyampaa peoples' negotiating of their selves and socialities means that responses to thinking and acting on health treatment advice can vary widely both between individual persons and for any particular person in different situations. This can lead to what appears to be irrational or inconsistent behaviour from the perspective of often despairing health professionals. Some will give up in frustration, even disgust, at times with their (even if unconscious) negative preconceptions about Aboriginal people seemingly confirmed: 'What can you do if they don't help themselves!' Their own task has been conceptualised within the framework of thinking about the self and the body that undergirds the Australian health system and the training of its professionals. The challenge is how to reconsider treatment in a situation in which 'self-as-social' is valued more than the notion of the individualised body-self. The individualising of health and health care exacerbates a situation in which Kooris as 'patients' are often dependent on those around them to take as much responsibility

ty for the patient as the patient themselves. The sick Koori is thus not only negotiating the normal demands of their social order but is also expected by health professionals to be getting others to respect and look after them when they have nothing to 'give' in response to the demands they would need to make of others. If Mum needs the fresh fruit in the fridge, how is she to deal with the contradiction between her body's health, her children's desires, the right of people in the household to help themselves to the contents of the fridge, and the cultural requirement that she, as householder, look after others. The impact of poverty is grim. It does not encourage sharing but makes it impossible to meet demands adequately. Relative economic deprivation places socialities under stress, exacerbating distress as the patient jostles the need to respond to culturally legitimate demands which are not, according to conventional medical wisdom, in her interests as 'patient'. This does not mean Mum doesn't care about her health. On the contrary, wellness is highly valued by Kooris. But it is not valued at the expense of social relations. The sick person could end up being seen as mean, and risks becoming lonely and thus far more 'dis-eased.'

Radley and Billig (1999: 28) challenge the tendency to speak about understandings of health and illness as if they are static and dichotomised, advocating a move away from beliefs about health and illness to what people say and do — their actual 'accounts':

they construct their state of health as part of their ongoing identity in relation to others, as something vital to the conduct of their everyday life. This means that the accounts that are given of health and illness are more than a disclosing of a supposed internal attitude. In offering views, people are also making claims about themselves as worthy individuals, as more or less 'fit' participants in the activities of the social world.

In other words, notions of health and illness are constructed, affirmed, reconstructed and negotiated within particular social contexts, even for the members of mainstream Anglo-American society with whom Radley and Billig are primarily concerned. Illness, feigned or real, can provide people with options about how and when they engage with others. Being healthy is not always a preferred option.

Within a Koori community, the number of people who define themselves as ill is likely to be far less than those who would prove to be clinically ill if subject to health checks. People who are sick may choose not to define themselves in this way. Being sick means taking action to change one's circumstances in preference to assenting to life's terms. Old Hannah would not go to a dentist and from time to time suffered excruciating pain from abscesses. 'It'll be alright', she would say, clinging on to her jaw for comfort while asking for the price of a can of soup because it was all she could eat. She saw the pain inflicted by the dentist as potentially much worse and to subject herself to it required relinquishing an autonomy she was not prepared to do (cf. Boulton and Macdonald, forthcoming). Ailments do not necessarily take people to the doctor and many are more likely to go to hospital as an emergency in an ambulance than through a choice they have made to have treatment. Irrespective of the initial reason for the hospital visit, this is a circumstance which can lead to the diagnosis of more serious but not so evident illnesses such as diabetes and diseases of the respiratory system. However, it also implies that some of these illnesses may be well advanced by the time they are noticed. Few Kooris have 'regular checkups': the fear of what treatment might impose socially can be more of a dilemma than living with pain or discomfort.

Our observations of the ways in which Kooris in these rural communities act on their understandings of illness help to explain what might look, to the health practitioner, as irrational, irresponsible or careless. That they are not irrational can only be understood through an appreciation of the different ways in which the social is understood and valued. From a Koori perspective, activities they prioritise at any particular moment are strategically evaluated and rendered meaningful in terms of their relationships with significant others *at the*

time. Their health, understood in purely physical or biological terms, is unlikely to take precedence over socially-defined commitments or desires. The disciplines and demands of a health regime are given due attention when these complement rather than conflict with social demands. But why does this conflict arise?

Illness inverts the customary rules of social relatedness, the conventionalised ways in which people relate to each other. There is a cultural expectation in Australia generally that, when a disease is diagnosed, family members and significant others will rally round to assist in the maintenance of the regimes required for a return to better health. Illness prompts concern on the part of family members to have a person returned to good health. The efforts of caring are restorative not only of that person's health but also of the roles that the same person fulfils from day to day. While Kooris are socially accountable, caring is rendered more complex in their case by the value placed on personal autonomy. Others should not take action which might be interpreted as infringing the rights or capacity of a person, however sick. The sick person must be prepared to *ask* for (demand) assistance if required, and they will need social credit to be able to do so. For the most part, people are expected to be responsible for themselves, putting additional pressure on the person who must juggle contradictory expectations, deriving from both social demands and obligations. Whether or not people visit a person in hospital may depend upon how highly regarded they are by their own kin, whether they have respect based on a lifetime of negotiating, for instance, the demands of sharing. The fear of isolation through medical treatment may stem in part from anxiety that one has not been doing the right thing by others or by the loss of the immediacy of social reinforcement.

LIFE AS CONTINGENT

Although there is much more that could be said to illustrate and expand our argument, we want to reiterate the key issues. We have argued that different notions of the relationship between 'self' and 'social' lead both to different ways in which time is valued and organised as well as different ways in which health, well-being and disease are understood and acted on. Koori notions of the social self produce a strategic use of time which recognises that life-as-contingent is the norm, and that the demands of sociality critical to the constitution of the self have to be negotiated as they present themselves. Our understanding is not that Kooris have a different concept of time, or of past, present and future, but that a different conceptualisation of the social and the self leads to different ways in which time is valued and used. Temporal notions, such as 'future', 'boredom', or 'patience', as well as understandings of the 'long-term' with regard to managing illness or money over time, have implications for the ways in which Aboriginal people experience themselves as ill or in need of health care. For Kooris to use the expression, 'Koori' time is to recognise not a different conception of time but the recognition that anything can come up to interrupt prior arrangements and that this should not be interpreted as undisciplined behaviour. The rhythms of life's demands, however, do differ.

We have used the notion of contingency to conceptualise the temporal dimensions of strategies through which Kooris negotiate the intersecting but sometimes contradictory demands of self, the body and social life. The Koori understanding of the self, as constituted in and inseparable from the social, places more emphasis on the primacy of the present over the future and makes planning, as a future-oriented activity, subject to the contingencies of life. The quality of social life is often privileged over the health of the body because Kooris are constituted as persons within the recognition and accommodation of the rights of others to make demands and the importance to the constitution and affirmation of one's self that they do so. Koori socialities are not dependent on the social in an abstract way but on 'presence' — constantly 'being there' as part of the social body. Not to be present is to risk missing out. Intra-Koori social economies, expressed through demand sharing, reflect the imme-

diacy of the present and the importance of presence. In the decisions that need to be made day by day, tomorrow is not present and will have to take care of itself. Money will be spent, for instance, to augment or enhance social engagements rather than on the self when such choices have to be made. This does not mean that they do not want to spend on the self, only that the social should and usually does take precedence. The poorer or more disadvantaged a person is, the greater this pressure, leading to a greater vulnerability for those who are often the more acute sufferers in terms of illness.

Contingency appears to make long-term planning for one's health and body impossible as various factors can seem to continually subvert planning and good intentions. But looking after your own advantage, health and well-being might end up being equated with self-centeredness. People who are economically better off are often described as 'anti-social' and 'nasty pieces of work' because it is assumed that their acquisition is only possible through selfishness, through not being prepared to respond to demands to share. It is possible for someone like that to be cared for, but only if those around her accept the same level of responsibility for her as patient as she does for herself. The individualising processes of medical care make this difficult. When a patient is diagnosed with diabetes, or has a broken leg, for instance, it is the entire family (and/or community) that then needs to be brought on board as having a responsibility to care for that person. She can rarely do it on her own in this cultural milieu, and yet this is what is expected. Health education, for instance, could be more effective if delivered to *everyone* in a patient's environment, regardless of age, kin relationship or state of health, so that it is more able to change the *social* environment of the sick person. Bessie's drinking friends needed to realise they had a responsibility to move to her, not her to them, or to go down to her place and/or help her walk across the village. Bessie needs to know these are legitimate demands. But this requires that medical and health practitioners thinking about illness and its treatment as social rather than individual so that they do not compound the difficulties for their patients.

The extent to which one can complain, can expect others to assist, and can make demands will depend upon the circumstances at any particular point in time. Radley and Billig (1999: 20) usefully employ the notion of social representations to grasp the dynamic between socially shared meanings and the ways in which individuals work with the constraints and possibilities of these for their own changing situations. In people's accounts of their illnesses (Radley and Billig 1999: 20) but also in the ways in which they act out 'illness', they are enacting the ways in which they understand their lives in general and their life chances at any given time. This is just as true of Kooris.

Illness is often conceptualised by Anglo-Australians as a legitimate reason *not* to engage in social demands. It is a legitimate reason not to go to work, and to make demands of others to care for one. But there are problems associated with being ill in this cultural milieu as well. As Radley and Billig (1999: 19) point out:

Being ill is not a simple matter: the entitlements must be seen to be earned and impoverishment appears 'natural' considering the circumstances ... Except in extreme cases (e.g. when in intensive care, having been involved in an accident), being a good patient means having to fulfil a sociologically ambivalent position. The patient must appear to be more than a patient; a display of healthiness, or normality, is also required, for the ill person to appear worthy of receiving the entitlements. If the ill person is only an ill person they will fail to warrant their special claims, as they will do so if they appear to be healthy. In this respect, the ill person is both more and less than a physically functioning body.

The risk is always that the ill person may overdo the complaints and be rejected by the well, or become too ill to participate in social activities but not sick enough to bring visitors.

Kooris tend not to make allowances for the sick. They will do so when visible disabili-

ty is evident, such as a deformity or use of a wheelchair; when the condition is immediately life-threatening. Even in the latter cases, a person will be treated 'normally' to a much greater extent than is often evidenced among Anglo-Australians. Illness is not an excuse for not 'doing one's bit', to whatever extent is expected. Even children are expected to take responsibility for themselves. Malingerers, hypochondriacs and habitual complainers get short shrift. The more effort the sick person makes, the more likely it is that they will be assisted and supported to facilitate their restoration to participation. Yet, while this might be good strategy in some cases, enhancing the prospects for wellness, it can work against the sick person who makes decisions in the interests of maintaining socialities which are not in the interests of their health. Because demand sharing permeates every part of the Aboriginal people world, the ability to share is important so as to activate the sets of obligations through which relationships are continually negotiated and tested, even close ones. Buying smokes or a flagon of wine may be more important than paying for the prescription medicine or fruits and vegies. This requires that people be active agents in defining, calculating and acting on the sets of often conflicting obligations which each person encounters throughout their day, every day.

This has two implications. First, understandings of health and illness will be derived from activities in which people make choices about how to represent themselves as 'sick' or healthy: these representations are not predetermined by a set of static beliefs. Such understandings are amenable to ethnographic analysis but do not lend themselves easily to generalised models. Second, and flowing from this first point, the idea of life-as-contingent is important for understanding how agency operates in the context of health care practice. What a Koori says about their state of wellness does not — no more than it does for most Australians in fact — depend upon some arbitrary and neutral description of physical ailments or measures of pain or discomfort. Their accounts of themselves are contingent upon who they are with and what action they are engaged in. This suggests that health care providers need intimate knowledge of the people for whom they care in order to assess the appropriateness of treatment. Brady (1995), in the context of alcohol dependence, has argued that non-Aboriginal medical practitioners can provide a useful external moral authority because they are not implicated in kin-relatedness. But whether the carers are Aboriginal or non-Aboriginal, they need to maintain respect, avoid becoming implicated in demand-sharing, and work at solutions to health care which enable social priorities to be realised more effectively.

CONCLUDING THOUGHTS

P.D. James, in her novel *Children of Men* (1992), captures the horror of a world without a future because women are no longer conceiving, children are not being born. The confrontation with the death of the known world that she depicts is far more alarming and debilitating than the death of others or even one's own death. There are reports that, in the nineteenth century, Aboriginal people whose worlds had been torn asunder in colonial incursions simply stopped having children. Life in a dissonant culture cannot but impact on any member's understandings of health, illness and mortality. It doesn't lessen the grief but it increases the resignation — and thus diminishes the will to struggle against the circumstances, however understood, that mean that 50 years of age is old, diabetes is normal and suicide is common.

Part of what makes death bearable in any society is the continuity of life. In post-religious industrial societies, this has translated into an illusion of immortality achievable through advances in health care. Aboriginal peoples seldom share this illusion and are not so absorbed in self-embodiment. However, their understandings of continuity are socially-defined: linked to their ancestors and to their children's children, life goes on. Hence their attention to funerals, where kin and community members come together in a reaffirmation

of on-going socialities (cf. Macdonald, in press). The Aboriginal focus — which includes its own illusions and contradictions — is, first and foremost, social rather than physio-biological functioning and connectedness. It establishes meaning for the self by socialising and engaging with others.

Accordingly, the key to understanding the easy way in which Kooris seem to use time lies not in the concept of time *per se* but in the relation between self and significant others. Kevin's comments, with which we started, present one example of the awareness Kooris have of the difference between 'saying' and 'doing'. This points to their *use* of time and their recognition of that fact that, in a life constituted as contingent, Kooris will use, experience and construct time in their negotiations of socialities as well captured by the notion of contingency. Contingency points to the fact as well as the value of the present, the unpredictable quality of life. Although there is past and future, time is neither a flow nor a cycle. It is a resource through which to negotiate and maximise the socialities out of which the continuing meaning of past, present and future will derive.

When Kooris look to a future, it is with an appreciation that the future is contingent. Selves which predominantly establish meanings for themselves through social interaction and negotiation recognise that 'time' implies contingency and spontaneity. Even while they plan future events, small or large scale, they do not succumb to the illusion of predictability. The implications for health practitioners are challenging and much requires to be done to develop sensitive treatment strategies for Aboriginal people that can adjust to contingencies. One clear implication is that health professionals, in aspiring to address the need for a 'healthy society' to achieve a 'healthy body', would do well to identify and include in the notion of treatment strategies, a particular patient's group of significant others. Bessie's fellow drinkers had at least as much and perhaps a greater chance than the doctor of exhorting her to keep her plastered ankle raised on a stool while they sat and drank together — but it may not have occurred to them at the time. Bessie will deal with tomorrow's outcomes of today's choices when tomorrow comes.

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