# Traditional Medicine and Biomedicine among Mapuche Communities in Temuco, Chile: New Forms of Medical Pluralism in Health Care Delivery

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***Abstract:*** Within Mapuche indigenous communities in Temuco, Araucanía Region, Chile, traditional healers (*machi*) and their healing practices are part of everyday life for many people. This article shows that there is a clear tendency for Mapuche people to combine different therapeutic approaches to solve their health problems. We argue, however, that this behaviour is not explained by a crisis of identity among the urban Mapuche community in which the person has lost his or her own indigenous cultural scheme but has not fully assimilated the Westernized model. This article shows that this form of therapeutic pluralism by urban Mapuche is motivated by the adoption of a holistic perception of health and of plural medicinal practices among these indigenous communities.

**Keywords:** traditional medicine, urban areas, Mapuche, Chile

***Résumé*** : Dans les communautés autochtones Mapuche de Temuco, région d'Araucania, au Chili, les guérisseurs traditionnels (*machi*) et leurs pratiques de guérison font partie du paysage quotidien de nombreuses personnes. Cet article montre qu'il existe une tendance claire chez les Mapuches à combiner différentes approches thérapeutiques pour résoudre leurs problèmes de santé. Nous suggérons toutefois que ce comportement ne s'explique pas par une crise d'identité parmi la communauté mapuche urbaine qui amènerait une personne à perdre les repères de ses propres schèmes culturels autochtones alors qu'elle n'a pas entièrement assimilé ceux du monde occidentalisé. Cet article montre que cette forme de pluralisme thérapeutique chez les Mapuches urbains découle de l'adoption d'une perception holistique de la santé et de pratiques médicinales diversifiées chez ces communautés autochtones.

**Mots-clés :** médecine traditionnelle, régions urbaines, Mapuche, Chili

## Introduction

Traditional medicinal practices are recognized as part of the primary health care delivery "system" in much of the developing world (Cantor-Graae et al. 2003; Cheung-Blunden and Juang 2008; Colvard et al. 2006), supposing such an umbrella system exists, since we will not claim here such necessary preexistent unity or coherence. According to the World Health Organization (WHO 2002), an estimated 3.5 billion people in the developing world depend on traditional medicine for their primary health care. Nonbiomedical healing systems vary across cultures, but the ontologies they bring into being have in common to maintain mind and body in relation to each other (Pieroni and Vandebroek 2007; Sandhu and Heinrich 2005). In the end, only biomedical approaches maintain this division, a paradigm separating nature and culture (Descola 2010), which appeared between the 15th and 18th century. Biomedicine distinguishes itself in this matter as it still maintains Cartesian dualism or a separation between body and mind, which for the most part are dealt with through distinct sets of practices. While this sets biomedicine apart from other ways of healing, it does not make it the sole solution to health issues. In line with its still current hegemonic positioning, tenets of biomedical practices tend to view any other ways of healing as remnants of the past or otherwise as alternative or complementary to biomedicine. Further, revivalism of indigenous medicine can be perceived as an identity crisis rather than as a practice that is simply useful in healing. To palliate such ways of marginalizing the legitimacy of indigenous medicine, anthropologists have long been attempting in different ways to treat it less as exotica and more as ways of healing within others, such as through the notion of medical pluralism.

What medical anthropologists refer to as medical pluralism is not a new concept (Kaptchuk and Eisenberg 2001). It appeared in the late 1970s as a useful way to understand the varying number of healing practices,

not as a process of elimination of variety or funnelling into a dominant practice but as being the *norm* rather than the exception. Charles Leslie's now classic *Asian Medical Systems: A Comparative Study* (1976) and his parallel in francophone anthropology as taken up by Jean Benoist, among others, in his anthology *Soigner au pluriel* (1996) may have initiated the idea. The wide literature that has emerged since requires some specifications as to how we will think about medical pluralism as complex open systems of medical practices that maintain themselves in relation to each other. Murray Last (1981) brought to our attention the importance of "knowing about not knowing" with regard to medical knowledge, by which he meant how little either patient or doctor needs (or wants) to know, hence bringing some doubts to the notion of all people having a "medical system." Last proposes to think in terms of "medical culture" rather than "medical system," essentially to grasp a particular hierarchy of both systematized and less systematized forms of knowledge in relation to medicine. Littlewood's (2007) edited volume uses a revised version of Last's seminal 1981 article, pushing further the idea of all medical cultures being more or less unsystematized due to generalized "not knowing" or "wanting to know." This acknowledgement warns of the use of "medical system" as convenient shorthand that implies a nonexistent unity and coherence. This is the route we will follow here, referring to medical culture as always being made, unfinished and, in this way, indeterminate and in constant negotiation to find the best ways to keep people healthy.

Throughout the history of medicine, there has been more than one medical paradigm competing for hegemony. In the larger historical context, the dominance of the Western global health model is relatively recent. However, the hegemony of the biomedical system has not eliminated other health practices, which although relegated to the *alternative* category in some instances, have not only remained viable but have increased in popularity (Kaptchuk and Eisenberg 2001).

In urban settings, immigrant indigenous communities often use traditional health care practices exclusively or in addition to conventional biomedical treatment (Corlett et al. 2003; Doel and Segrott 2003). Interest in receiving such traditional care may be in response to concepts of disease that are not recognized by biomedically trained physicians. Traditional medicinal treatments often provide culturally familiar techniques that treat both the physical and spiritual condition of an individual (Balick et al. 2000; Waldstein 2006). As people leave their native surroundings and migrate to urban centres, they bring their medical traditions and knowledge with them. In Temuco, Araucanía Region, immigrant peoples continue to import, buy, sell and utilize herbs and other traditional remedies to serve their own ethnic communities (Bacigalupo 1998; Balick and Lee 2001).

The present article aims to contribute to the understanding of the phenomenon of medical pluralism among indigenous people in urban areas by illustrating the process of cross-cultural adaptation among traditional healers (*machi*), biomedical doctors, and Mapuche people who consult both of them for their health issues in Temuco. Attention will be paid to the meaning and relevance of therapeutical practices and itineraries and their associated knowledge and beliefs as revealed by 40 Mapuche residents of Temuco.

## Practices in Medical Pluralism

The contemporary world contains impressive variations of images of health, modes of health maintenance, efforts of prevention, and illness experiences (Green et al. 2006; Han 2000; Kirmayer 2004; Nguyen 2003). By virtue of its disciplinary orientation—namely, to study cultures other than Western—anthropological classification of medical systems and knowledge systems in general has often been dualistic. The binaries of "biomedical" and "ethno-medical" systems (Fabrega 1972); "illness" as defined by the people, therefore cultural, and "disease" as defined by biomedicine or allopathy, therefore a physiologic reality (Kleinman 1980); "episteme" and "techne" (Marglin 1990), and Western "epistemic knowing" and Eastern "gnostic knowing" (Bates 1995), are some notable examples of dualistic classification.

In this dualistic approach and notion of culture as forming closed "systems," health typologies are all described primarily as "Western" and "non-Western" forms of knowledge; thus, they are defined only in relation to the West (McMahan 2002; Roof 1998; Van der Veer 2001). Such reductionism seeks to contain the diverse genres of the so-called "non-Western" knowledges or, for that matter, even the diverse genres of Western knowledge, in one undifferentiated category (MacPhee 2003). In the resultant typology, instrumental action, experimentation, logical thinking, individualism and causality are all attributes of one form of knowledge, namely "Western science," as against the attributes of expressive action, meaningful performance, holistic thinking, sociocentricism and participation, on the side of the unidentified "other" (Greenhalgh and Wessely 2004; Hernández 2003; Kaptchuk and Eisenberg 2001).

Nowadays, this dualistic perspective of health and health "systems" as coherent unified entities is beginning to fade and different ways of interpreting the relations between "Western" and "traditional" health practices have started to become more popular among health practitioners and scholars (Greenhalgh and Wessely 2004; Hernández 2003; Kaptchuk and Eisenberg 2001)—in particular, the emergence of the pluralistic understanding of ways of healing since the 1980s in the field of medical anthropology.

Approaches that see the "other" only in terms of, or opposed to the West, ignore the internal logic and nuances of the open-endedness of "cultures" and of medical "systems." There is, therefore, an urgent need to examine the multiplicity and dynamics within the so-called "other" (Hahn and Inhorn 2010; McFarland et al. 2002), within biomedicine as well as at the interstices of varying healing practices.

In an apparent attempt at transcending the distance that had marked anthropological engagements with non-Western ways of knowing, Good's (1994) phenomenological approach tries to avoid dualistic categories by accommodating multiple voices or "heteroglossia" in the study of the disease experience. This approach makes an effort to be culturally relativist or, more precisely, to explore relations between ways of knowing and not knowing as opposed to comparing "medical or cultural systems," and to acknowledge the plurality of medical knowledge. Yet, like other anthropological excursions into non-Western societies, it too, is ultimately limited by being chiefly an instrument for defining the West's own identity or deciding the attitude the West should take toward the "other" (Torry 2005). The point of reference should not remain the West, as it is only part of the plurality that is to be understood or at least partly understood, as it remains knowledge in the making in all cases.

The permutation and combination of different levels of textual and professionalized knowledge produce configurations of medical knowledge which are far more complex than what is conveyed by the dichotomous classification, "biomedicine" and "traditional" medicine (Chen et al. 1994; Good and DelVecchio 1995). Medical anthropologists have been attending to this issue for the past decades, proposing various solutions to grasp knowledge as they travel through space and time, such as proposing such notions as "body multiple" (Mol 2002) or "local biologies" (Lock and Nguyen 2010), thus transcending mind/body and them/us dichotomies. As we shall see below, these fields of knowledge in healing may be better understood as nodes in networks rather than as dichotomous entities. The term *medical pluralism* will be used here to refer to these combined uses of the different medical practices that emerge from the multifarious cognitive positions of the expert (the doctor) and the traditional healer, yet also of the people who move through these experts' healing services. Local knowledge and social environments, such as family and social contexts in which the individuals are situated, are part of the ways people seek health, and it is through these contexts that certain experts are consulted (or not). From this perspective, health is seen as not simply originating in individuals themselves or deriving strictly from social forces but as being engendered in complex interactions between individuals and their social contexts (Kirmayer 2003, 2004; Trevathan et al. 2007)—hence, a co-production of knowledge through looping effects between the inhabited world and lived experiences of (dis)ease and healing.

We will provide an understanding of two main medical cultures coexisting in the Araucanía Region in Chile supported by a field analysis carried out in the city of Temuco. Traditional medicine in the area under study is practiced not only by Mapuche traditional practitioners, epitomized by the machi, or Mapuche shaman, but also other forms of traditional healers called *yerbateros* or *materos* ("herbalist"), who are specialized in treating several complaints mainly using plants or herbal infusions. These traditional healers are experts in using medicinal plants, but, contrary to the machi, they do not use spiritual powers to heal people who consult them and are unable to treat diseases produced by supernatural or magical entities or influences.

This article argues that use of both Western and Mapuche medical practices by indigenous people in Temuco is not obligatorily motivated by a situation of conflict and disorientation in which the patient and his family turn to different medical resources. We argue that this behaviour does not necessarily suggest the presence of a crisis of identity among the Mapuche living in urban areas, in which the patient has lost his or her own indigenous cultural scheme but has not fully assimilated the new one yet. On the contrary, we aim to show that this movement between different sets of practices is constantly negotiated in terms of what procedure seems to fit best with the health problem in question, how a treatment seems to work, what its related costs are, and with regard to what is known and preferred not to be known or left to the care of the preferred expert. Medical culture is in this way negotiated and made in the everyday with what seems to best fit the (dis)ease.

## Methodology

This study is based on three months of field research undertaken in Chile, Temuco (IX Region) in 2009. Temuco is a city with a population of some 300,000 inhabitants, located in the Araucanía Region, 670 kilometres south of Santiago. Temuco presents the highest percentage of people of Mapuche ancestry. During this study, we interviewed a sample of 12 traditional healers and 40 patients who visited them. To complement the collected data, five in-depth interviews were also carried out with medical doctors at the Makewe hospital. Key informants were selected following the method of a reference chain through some local informants and acquaintances in Temuco. Almost all the patients interviewed belonged to the Mapuche community and lived in Temuco or in its periurban areas. To reduce the bias possibly introduced to the data because interviewees were patients who visited machi, this sample has been completed with 20 Mapuche patients of the Makewe Hospital, in proximity of Temuco.

While carrying out investigations of medicine and healing practices, a recurrent difficulty is to understand diagnoses and treatments in medical practices that differ in their assumptions and principles from those of Western medicine. An important aspect of this study has been the development of a methodology that takes the differing ontologies brought into being into consideration. The traditional practitioners who participated in this study were recognized as experts in their healing tradition, and they were frequently consulted with questions regarding concepts such as the etiology of certain diseases and the specific terminology used to identify some health conditions in Mapuche culture. On the other hand, biomedical doctors were consulted for the explanation of disease and terms that were unclear. In both cases, this helped reveal what each expert aimed to know and what he or she would rather leave to others to deal with in his or her practice, and what legitimized as useful health-related knowledge. Our intention with this approach was to ascertain the relevant diagnostic criteria as defined by the healers and to avoid imposing biomedical perspectives as a frame of reference, as well as the other way around.

Most people who are recognized in the community as traditional healers and who prescribe herbal remedies do not hold official qualifications or licenses; referrals are by word of mouth, and their "credentials" are based on community consensus. The selection of traditional healers was, therefore, based on referrals from the community. We met with the referred traditional healers, and an initial informal interview took place. This exploratory interview had the objective of gathering some initial data about the traditional healer and assessing if he or she met the critieria the first author set for including these traditional healers in the final sample. The criterion used in the final selection was professional experience, measured in terms of the number of people treated and years of experience in treating (dis)ease. The neighbourhoods of Pueblo Nuevo and Santa Rosa were selected for investigation because of their high concentration of Mapuche communities. We asked people working in community organizations and staff in health food stores and *botánicas* to help us identify healers who were active in the area. Botánicas are shops that sell several types of merchandise such as fresh and dried medicinal plants, tonics, books and religious and spiritual items such as candles and incense.

The study involved two stages of data collection: first open-ended, in-depth interviews with practitioners to obtain information about their background, training and methods of practice, and, second, semi-structured interviews with practitioners; these took place immediately following a consultation, to elicit the diagnostic approach and rationale for treatment. Tape-recorded interviews and consultations were conducted in Spanish, transcribed and then translated into English. Content analysis was used to examine the interview transcripts, and the themes that emerged from the data were grouped into categories such as healing processes, uses and perceptions of allopathic and traditional medicine, advantages and disadvantages of using both medicinal practices, and possible therapeutic overlapping of both traditional and allopathic treatment. All patients and all but one practitioner agreed to be audiotaped; the information from the untaped interviews was entered onto questionnaires and supplemented with extensive notes. To preserve the privacy of the interviewees, the names were omitted or changed.

## Traditional Healing Practices among the Mapuche

Traditional Mapuche healers, machi, are mostly female practitioners. The interviews with the traditional Mapuche healers highlighted that a machi is chosen by "Chaw Ngenechen" (a spirit guide) and called by dreams or visions when she is relatively young. A new machi inherits the spirit of an ancestor through her matrilineage, commonly a grandmother. After having experienced the dream or vision, there is an acknowledgement of the invocation that occurs through an illness of the future healer, which must be cured by a machi. If this invocation is not acknowledged, this individual will remain sick her entire life.

When the future machi accepts the call, she must then find an elder machi who will help train her. This training is a long and expensive process. Healing involves a basic logic of transformation from sickness to wellness that is enacted through culturally salient metaphorical actions, such as the use of plants and of musical instruments and enchantments. Agreeing with Albretch and colleagues (2000) and Brown (2008), we argue that the transformations of healing involves a symbolic mapping of bodily experience onto a metaphoric space represented in the ritual. At the heart of any healing practice are metaphorical transformations of the quality of experience (from feeling ill to wellness) and the identity of the person (from afflicted to healed). Once established, a machi treats patients at a small health centre usually built by the community beside her home. Machi are usually paid by their patients in cash or goods according to their ability and depending on the seriousness of the illness and the effectiveness of the cure (Barnes et al. 2007). This compensation agreement is consistent with traditional Mapuche norms of economic reciprocity in social relationships.

The machi I interviewed generally use empirical and natural methods (herbs and occasionally natural pharmaceuticals), together with other magic and spiritual methods that are part of their rituals: prayers, singing and playing the *kultrun*, a traditional instrument. The traditional healers emphasized how using these methods can simultaneously strengthen their healing powers and, thus, increase the effectiveness of these healing rituals.

## *Therapeutic Itineraries*

The Mapuche people interviewed were asked how they have been healed by the machi and if they consider the machi to be the right person to visit in case of an illness; if so, they were asked for which illnesses would they go to see a traditional healer. The analysis of the patient interviews indicated that 65 per cent of the 40 patients visited both machi and doctors. Indeed, the Mapuche and Western practices were often consulted simultaneously or alternately; 9 per cent used only Mapuche medicine, and the remaining 26 per cent used only Western medicine.

The importance of combining the two medical practices was emphasized by a Mapuche woman in her sixties who affirmed that the two treatments were necessary. First, the Western treatment was used to heal the physical pain or the wound. The second treatment was the Mapuche healing practice, which purifies the mind and helps heal the soul. According to this interviewee, every illness has a spiritual and physical side and therefore must be treated by a machi and a doctor. This woman, to emphasize her point of view, told how Vanessa, her two-year-old grandchild, injured herself when she went outside the house to play. Her father was using a tool to cut the grass and Vanessa hit her head on the tool and cut herself. The child was treated at the hospital but soon the sutured wound became infected and Vanessa became feverish and was taken to the hospital in Temuco. Nevertheless, the child could not sleep properly; she was hearing noises in the rook and said she was still in pain. The grandmother suggested bringing the child to see a machi, who said that there was a spirit (*xafentun*) in the form of a dog outside the house that wanted to take away the baby. The machi gave a remedy to the child and performed a ritual. The interviewee stressed that subsequently the noise in the house stopped overnight and the child began to sleep.

When asked whether a doctor or a machi was most effective in curing a patient, 17 interviewees out of 40 answered that a Western doctor can cure every disease, while 26 interviewees (more than 50 per cent) said Western doctors can cure some but not all disease. These results indicate that Mapuche patients believe both medical practices to be crucial to resolve their illness. Interviews emphasized how, in many cases, patients take a pragmatic approach vis-à-vis health and illness and that the medicinal system to which they address themselves (i.e., Western medicine or traditional Mapuche medicine) is the one that they consider to be more effective for their particular health complaint. The following interview response reflects this point of view:

> The machi are effective in healing a patient. Seeing both doctors and machi seems very good to me. Because sometimes people get better with Western medicine but sometimes people also get better with machi's medicine. Or, if a machi can not cure people, they send them to the hospital. I think this is really good.

In reference to the simultaneous recurrence pattern of different therapeutic practices, some individual patients adopted a rather pragmatic strategy: he or she used all the resources at his or her disposal to solve his or her health problems by combining various strategies, technologies and therapeutic agents belonging both to Western and Mapuche medicine. This attitude is evident in the behaviour of Alfonso, a 55-year-old Mapuche man who had a serious infection in his knee. At first Alfonso was treated at home, but seeing no improvement, he decided to go to a hospital. There the doctor treated him and advised him to stay at the hospital for a few days for further treatment. Despite this, the man's infection kept recurring, a situation for which he consulted a

machi who lived near his community. The machi diagnosed a "spiritual disease" or "supernatural disease" (*Wekufu* disease) and made a *machitun*, which is a therapeutic ceremony consisting of reciting prayers and using traditional musical instruments.

An exclusive therapeutic demand (intervention of a single medical practice) from a machi occurs in pathological situations in which several circumstances and evidence show unequivocally that the (dis)ease has a supernatural origin, and thus treatment operates only at that level. For instance, use of non-Western medicine is particularly frequent in cases of illness such as mental problems, depression, or the "evil eye," as it is believed that physicians fail to recognize these types of illnesses and therefore cannot effectively cure them. As one interviewee put it, "Doctors do not know anything about witchcraft and spiritual and Mapuche diseases. They also do not know how to make a diagnosis by looking at urine." For instance, there is knowledge among Mapuche communities that *kalkutun* (presence of an evil spirit) cannot be diagnosed or resolved by Western doctors. José, a 60-year-old Mapuche man from Lumaco village who lives most of the year in the city of Temuco, realted:

> About two years ago I was about to leave for Lafken [the world of the dead] ... a woman put something wrong in my drink ... I became very thin, weak, I went to the machi and she treated me, she made me machitun (a special ritual), but it took more than a year of herbal treatment ... now I have finally recovered, but it was pretty hard to overcome my illness.

The case of David is quite illustrative of machi healing abilities in certain instances. A young Mapuche in his late teens, David states that he was taken to a hospital when he was one year old because he could hardly breathe. The doctor who attended diagnosed that David was born with a very soft larynx. They explained that with time, this may resolve itself spontaneously, but if it persisted, the baby should be visited by an otolaryngologist. A neighbour of the family suggested going to see a machi, who explained that this complaint was because the mother of the child killed chickens while she was pregnant and now the child produced a sound that resembled the sound of a chicken when it is being strangled. According to the machi, an evil force (*nentukonüinchefe*) must have entered the fetus during the fourth month of gestation, as before that the child is not sufficiently developed. The machi told the parents that the baby would feel better within four days. In the interview, David's mother confirmed that healing occurred as predicted.

The machi attend many sick people, both Mapuche and non-Mapuche, who are not completely satisfied with the diagnosis and treatment available at the hospital. The patients interviewed also emphasized that they go to see a machi when the doctors cannot diagnose an illness but they keep on feeling sick (e.g. when the doctors diagnose an illness as psychosomatic) or if the hospital treatment and pharmaceutical drugs do not relieve their ailments. Many patients we interviewed affirmed that the machi knows how to cure their illness with medicinal herbs, and they hold the machi in high esteem for their ability to make a diagnosis of an illness without complex and sometimes costly and painful medical checkups. The patients interviewed, often emphasized the machi's capacity to give some indication of the future evolution of the illness through their alleged capacity for divination. This way of tackling the illness and its diagnosis is culturally significant for many members of the Mapuche community. Indeed, knowing the etiology of the illness right away allows the patients and their families to become aware of the situation affecting the patients. In Mapuche traditional medicine, afflictions are understood to involve a wider social network; thus, healing practices should therefore address that larger system (Conrad 2007; Summerfield 2002).

When seeing a traditional healer, the Mapuche patient and his or her family maintain cultural control over the process of health and disease, following a familiar cultural pattern, perhaps more so then when seeing a doctor, although some familiarity exists there as well. The deep connection between patient and healer is rarely present between patient and doctor in the case of Western medicine. Although many Mapuche choose to go to a doctor for treatment, two-thirds of the interviewees emphasized how indigenous people are often discriminated against by Western doctors. These patients highlighted how, on many occasions, the doctors did not spend time explaining their clinical situation and quickly dismissed them. As a result, these patients felt uncomfortable as they were not fully aware of the disease they suffered and felt themselves to be the object of discrimination.

One of the most common criticisms from the machi interviewees was that doctors are sometimes too rigid with their patients and do not allow them to relax and be cured in a "positive" environment surrounded by friends and relatives. One machi commented, "Many times hospitals make patients feel worse. Patients are in an 'artificial' environment and physicians do not measure the side effects that the remedies prescribed for them can cause." According to the point of view of the majority of patients interviewed, the machi gives

personalized service and offers a holistic treatment that, according to the interviewees, is not commonly found when consulting Western doctors.

It should be noted that the type of choices Mapuche patients make regarding the different medical systems does not depend solely on cultural considerations. Certain material factors profoundly affect the behaviour and the strategy with which one copes with the illness. The interviews emphasized that a crucial condition affecting the choice of different options is economic. In some cases, the medical treatment provided by Western practices, being free of charge (in hospitals, clinics and rural health posts), attracts members of the community, not because there is high identification with the therapeutic strategy but because of availability and accessibility to the treatment. Conversely, in other cases, the high cost of surgery, trips to the hospitals or the possibility of dying away from the family may deter families from using the official medical resources. In this regard, it should be noted that one of the current effects of the disintegration of the solidarity mechanisms in the Mapuche community has been the rise of costs for many services by traditional healers, consequently restricting access to this recourse by the members of the Mapuche community. In the face of existing barriers that restrict access to health care, one response from immigrants has been to fall back on folk and popular health resources that are accessible and familiar to them (Greenhalgh and Wessely 2004; Kirmayer 2004).

Yoon and colleagues (2004) explain there are push and pull factors that influence the choice of health care sought. According to the push-pull model, a lack of health insurance or attitudes of professional health care providers act as a pushing force toward the use of traditional healing modalities. The pull factors that draw people toward traditional health systems include cultural fit, familiarity and belief in the effectiveness of traditional methods. Greater understanding of push and pull factors is needed to close the gap between professional and traditional health sectors.

This point is clearly illustrated by the experience of Carlos, a 50-year-old man who suffered headaches for years. According to the family, he was very sick and could barely work like the rest of the farmers in their community. On several occasions he went to see a machi, who diagnosed the impossibility of his recovery, a situation which seemed likely as all his sisters had died from a similar cause. One day Carlos went, with a urine sample, to see a machi in Cuidad Imperial, a city two hours from Temuco. The machi prescribed herbal remedies and homeopathic medications to cure the pain. As Carlos got worse, he decided to see two doctors whom he had previously contacted. One doctor diagnosed him with depression. Both of them recommended transferring Carlos to the hospital to do more analysis and more accurate diagnosis. The family opposed this transfer as it implied expenses they were not in a position to pay. Once they knew that the local medical services would cover the costs and risks of the transfer of the patient, the family agreed to send Carlos to the hospital.

### *Mapuche Community and the Healing Role of the Machi*

The current difficult economic situation of the Mapuche, who have historically been deprived of their land in Araucanía by the government, has progressively transformed their traditional lifestyle. In the last few years, land shortages and economic problems have forced a growing number of Mapuche to seek work in the city or to become labourers in the farms owned by white Chileans. In some cases, having lost control over large extensions of their territories, their economy forced them to adopt the forms of exploitation of small rural landowners where each nuclear family is a relatively autonomous productive unit (Ray 2007).

It needs to be remembered that the Mapuche in Araucanía have progressively been impoverished in the aftermath of the Chile's military occupation of the area and the consequent territorial division of it into indigenous reservations. The reservation economy progressively condemned the Mapuche to a life of destitution, hence favouring urban migration (Ray 2007). As José, a Mapuche man in his early fifties affirmed, "The problem is that we have no land to work. Because I couldn't find work in the village, I migrated to Temuco."

Currently, 80 per cent of the Mapuche population lives in the city, where they are often the object of social discrimination (Hernández 2003). Many Mapuche feel uprooted and alienated in the city. The interviews emphasized how a sentiment of anxiety is particularly present among the younger generations of Mapuche. One of the machi interviewed was surprised about the number of children and young people who come to visit her. Most of them suffer from "depression"; at least that is how they have been diagnosed by psychologists.

Being a machi is still highly regarded within the Mapuche community; their advice and intervention is considered by Mapuche patients to be both culturally acceptable and appropriate to the new demands of the modern Chilean society. The capacity of the Mapuche traditional healers to sooth the feeling of alienation that numerous members of Mapuche community experience in the urban areas is emphasized by a middle-age patient.

She affirms that "the machi thoroughly knows Mapuche culture.... When I visit a machi I feel at ease as I know they can understand my cultural background, the values with which I have been brought up."

### *Challenges Ahead Influencing Therapeutic Pluralism*

The situation of medical pluralism in Temuco still has some challenges ahead. One of the main challenges is the strong link between biomedical practices and Christianity; more precisely, from the evangelists who forbid consultation with machi and their healing ceremonies. As highlighted in the interviews, the Christian faith undermines traditional medical practices in Temuco, thus maintaining the opposition of the two sets of practices. Although this may enhance the maintenance of plural medical practices, the growing influence of Christianity may overshadow machi practices since machi are highly condemned. Thus, if a Mapuche participant is evangelical or belongs to any Protestant church, she or he tends not to see machi due to religious beliefs. In the last decades, the rise of Protestant churches has become a common phenomena in most Latin American countries, Chile included (Barrett et al. 2001; Patterson 2004).

There were several evangelic or Protestant nurses and workers in the hospital. Such workers did not have anything against the study of herbal medicine or the use of herbal medicine in the hospital but expressed uneasy feelings toward machi, whom they often associate with evil forces and witchcraft. Pablo, a 37-year-old Mapuche man who belonging to an evangelic church, believes all that a machi can do is to ask for the help of their gods. They say, "'God-Father, you who lives in the plants, help me.' But how can God possibly live in the plants? He is in heaven.... The machi work with the evil forces."

A member of the Mapuche community expressed her deep scepticism and mistrust toward the machi and traditional practices:

> My dad was ruined by going to see a machi. He always went to see machi when he was sick. We paid them and with it we went bankrupt. So I think it is better to see a doctor for any disease. The machi was working with the devil. My brother once did not pay a machi after a visit and she cursed him: he works hard in his fields but his harvest is never abundant and many of the animals that he breeds have died. One has to be very cautious with the machi.

Another aspect that influences the choice of one or another medical practice is related to the social prestige and power relations associated with a therapeutic practice and its cultural tradition. Using Mapuche medicine is still, in some ways, perceived as a sign of backwardness and superstition. Meanwhile, as the interviews with some members of the Mapuche community emphasized, to use Western health services is seen as socially acceptable and prestigious (i.e., modern) within the community. In some cases, the machi have lost their appeal among younger Mapuche who have grown up in urban areas and have begun to doubt the existence of spiritual diseases. They prefer to turn to modern medicine to solve their health problems. According to Ramiro, a young Mapuche in his early twenties, "If the hospital is closeby, young people go to be treated there. Young people feel that doctors ... are smarter, do not believe the Mapuche traditions and go to the hospital."

This scepticism and occasional denial of traditional Mapuche practices, sometimes present among the younger generation, is confirmed by machi Rosa:

> Young people do not believe in machi. They view them with contempt because they believe they are related to witchcraft. I did not believe in the machi, not until I became one myself. Now, many young people who have gone to the city have been mistreated. They have suffered disappointments and illnesses and are now returning to the traditional practices of the machi.

## Mapuche and Western Health Medicine: Practices in Parallel

The interviews show that almost no doctors referred their patients to Mapuche healers for consultation. In contrast, about 20 per cent of patients were referred to the Western system as a way of supplementing their treatment with specific health problems. This supplementary approach usually occurs with advanced forms of cancer, infections, severe trauma, heart disease and other serious illnesses. Western medicine offers quantitatively fewer referrals to other medical practices, a strategy which is consistent with its position of prestige and social prominence. An exception is the field of psychiatry, where there are some Mapuche patients being referred for consultation to the machi (Bhui et al. 2003). In some cases, as confirmed by some biomedical doctors working at the Temuco hospital, the psychiatrist has also sought the collaboration of these machi for the care and treatment of patients.

Although there have been some attempts to institutionalize indigenous medicinal practices in Temuco and the Araucanía Region (Alegría et al. 2008; Belliard and Ramírez-Johnson 2005; O'Neil et al. 2006), a problem is posed by the fact that most biomedical health professionals do not receive appropriate initial or ongoing training in cultural sensitivity and often lack under-

standing of the indigenous population. This was noted by three out of five of the doctors interviewed, who emphasized their initial difficulty understanding beliefs and practices that are radically different from those of the Western world.

The overall idea from the current dominant health institutions is that a machi cannot help a patient, since she did not complete a university education to become an official doctor. This lack of consideration toward the medical practices of the Mapuche is widespread among Western medical staff (Kim 2001; Vicente et al. 2005). Conversely, this attitude is rarely present among traditional healers, who have learned to appreciate the effectiveness of official health services and to integrate the resources of modern medicine into their therapeutic strategy. This can be explained by their openness to treating both mind and body, while the medical profession largely dismisses the first or separates the two. Also, because their code of ethics forbids them to do so, physicians are not comfortable referring patients to Mapuche healers because of their concern that the governing body of the College of Physicians might censure them. Despite increased acceptance of indigenous medicine practices by physicians, particularly in the last several years, a concerted effort is still required to develop medical curricula that engage students in medicine and other health professions, to increase their understanding of the traditional Mapuche medicine system and cosmovision.

## Conclusion

The phenomenon of medical pluralism is not a marginal phenomenon in urban areas in Chile. In urban areas there is a constant flux and change of cultures and the ways in which historical and cultural ruptures present important contexts for healing (Fauconnier and Turner 2002). In these accounts as well, new and ancient healing practices address core values and concerns in which both individuals and communities have a profound stake. In multicultural urban settings, tradition and healing practices often undergo creative change and hybridization (Kirmayer 2003). This trend might, in future, create a process of growing hybridization and syncretism in terms of ideology, practices and treatments among the various healing practices.

As this article has shown, such a process has lead Mapuche medicine to work with various tools and ideas coming from biomedical practices. The reasons why Mapuche patients in Temuco use both Western and traditional medicines are numerous, having to do with cultural and socio-economic considerations, the availability of local health services, and, of course, efficacy of treatment in one or the other set of practices. This referral to plural medical practices and experts is consistent with the state of the identity of the population, which is today subject to rapid change and contact processes that affect various aspects of the Mapuche community. In this fluid context, the practices of the machi are maintained and differentiate themselves from Western medicine. However, new elements are borrowed through interactions with biomedical practices as people use both types of practices alternatively. This process can be considered a form of creativity and innovation in indigenous medical culture and it shapes biomedical practices as well. The borders between the medicinal practices in Temuco seem sometimes to clearly define themselves, while the passage from one to the other by the same individuals surely creates a plural understanding of health and healing.

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